STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155389		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/22/2013	
	PROVIDER OR SUPPLIED		STREET 1316 N	ADDRESS, CITY, STATE, ZIP CODE I TIBBS AVE NAPOLIS, IN 46222	•
(X4) ID PREFIX		EFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE ADPROPRIE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	This visit was state Licensur Survey dates: and 22, 2013 Facility number Provider number: Survey team: Donna M. Smi Mary Jane Fis Maureen New Cynthia Stram Gloria Bond, Fi Census bed ty SNF/NF: 47 Total: 47 Census payor Medicare: 23 Medicaid: 23 Other: 1 Total: 47	for a Recertification and re Survey. March 18, 19, 20, 21, er: 000473 ber: 155389 100290410 th, RN-TC cher, RN ton, RN el, RN RN el, RN		CROSS-REFERENCED TO THE APPROPRI	ATE
	IAC 16.2. Quality Review	n accordance with 410			
	04/03/2013 by	Brenda Nunan, RN.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TM6211

Facility ID:

(X6) DATE

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		COMPLETED
		155389	B. WING			03/22/2013
	ROVIDER OR SUPPLIER		1310	ET ADDRESS, CITY, STA 6 N TIBBS AVE IANAPOLIS, IN 4622		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DDOMIDED'S DI	AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE	E ACTION SHOULD BE D TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFIC	CIENCY)	DATE
F000156 SS=A	CHARGES The facility must orally and in writing resident understate all rules and regulation to the facility. The facility is the resident with State developed Act. Such notificate or upon admissionstay. Receipt of a mendments to it writing. The facility must entitled to Medicate the time of admissions or, when the resident may amount of the charged; the services that the the resident may amount of charge inform each resident may amount of charge inform each resident may amount of charge inform each resident may amount of charges for the the periodically during services available charges for services for services or by the dicare or by the services or by the services or by the services or ser	inform the resident both and in a language that the ands of his or her rights and alations governing resident consibilities during the stay be facility must also provide the notice (if any) of the under §1919(e)(6) of the ation must be made prior to an and during the resident's such information, and any the test information, and any the test information, and any the test information inform each resident who is add benefits, in writing, at the side to the nursing facility dent becomes eligible for the sent and services that are any facility services under the resident may hose other items and facility offers and for which be charged, and the set for those services; and dent when changes are is and services specified in (A) and (B) of this section. Inform each resident time of admission, and gother resident's stay, of the in the facility and of the services, including any coes not covered under the facility's per diem rate. Infurnish a written description				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 2 of 84

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		I DDIG	00	COMPLETED	
		155389		LDING		03/22/2013	
			B. WIN				
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
MEGERA		CENTER		1	TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A description of t	he manner of protecting					
	personal funds, ι	ınder paragraph (c) of this					
	section;						
	•	he requirements and					
	procedures for establishing eligibility for Medicaid, including the right to request an						
	assessment under section 1924(c) which determines the extent of a couple's						
		urces at the time of					
	•	n and attributes to the					
	community spous	se an equitable share of					
		cannot be considered					
		ment toward the cost of the					
		spouse's medical care in his					
	•	spending down to					
	Medicaid eligibilit	ty levels.					
	A posting of nam	es, addresses, and					
		ers of all pertinent State					
		groups such as the State					
		ication agency, the State					
	licensure office, t	he State ombudsman					
	program, the pro	tection and advocacy					
		Medicaid fraud control unit;					
		that the resident may file a					
	•	e State survey and					
		cy concerning resident					
		and misappropriation of					
		in the facility, and with the advance directives					
	requirements.	with the advance directives					
	The facility must	inform each resident of the					
		and way of contacting the					
	physician respon	sible for his or her care.					
		prominently display in the					
		ormation, and provide to					
	•	plicants for admission oral					
		nation about how to apply					
	ioi and use Medi	care and Medicaid benefits,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 3 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		155389				03/22/2013	
			B. WIN		ADDRESS SITY STATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		l	ADDRESS, CITY, STATE, ZIP CODE		
MEOTO		OFNITED			TIBBS AVE		
WESTPA	ARK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ve refunds for previous					
	1	d by such benefits.					
	Based on reco	rd review and	F00	0156	The creation and submission of		04/16/2013
	interview, the f	acility failed to ensure			this Plan of Correction does no		
	a telephone co	nsent for ABN			constitute an admission by thi		
	(Advance Bene	eficiary Notice of			provider of any conclusion set		
	•	was followed up with			forth in the statement of deficiencies, or of any violation	n of	
	,	obtain the resident's			regulation. This provider	1 01	
	•	rty's signature for 1 of			respectfully requests that this		
		onsent in a sample of 3			2567 Plan of Correction be		
	•	•			considered the Letter of Credi	ble	
		coverage reviews			Allegation of Compliance and		
	(Resident #36)) .			requests a Post Survey Revie	W	
					on or after 4/16/13. (1) After		
	Findings includ	led:			telephone consent is obtained		
					copy of the ABN notice will be sent with return receipt		
	Resident #36's	notice for Medicare			requested. This will be noted i	n	
	non-coverage	was reviewed on			the beneficiary record and the		
	1	e record indicated, on			receipt will be attached to a co		
		esident "refused to			of the ABN notice for retention		
		derstanding the			the file. (2) Review of records	i	
	_	same record also			shows no other resident was		
					affected. (3) A new policy has		
		esident's responsible			been put into place requiring t	hat	
		ied via telephone on			after telephone consent is	otico	
	this same day	(10/15/12), and a			obtained a copy of the ABN no will be sent with return receipt		
	phone consent	was obtained.			requested. This will be noted i		
					the beneficiary record and the		
	On 3/22/2013	at 9:15 a.m., during an			receipt will be attached to a co		
		Social Service Director			of the ABN notice for retention	in	
	indicated she r				the file. (4) Administration will		
	approval from	•			monitor weekly at the Medicar	e	
	• •				meeting. This procedure will		
		rty on 10/15/12 but did			apply to all Medicare beneficia		
	not obtain a siç	gnea consent.			requiring notices of non cover	age.	
		MENT OF HEALTH					
	AND HUMAN S	SERVICES Centers for					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155389	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/22/2013
	PROVIDER OR SUPPLIE		1316 N	ADDRESS, CITY, STATE, ZIP CODE TIBBS AVE APOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Second Edition	edicaid Services n," dated April 2011, ollowing related to			
	contact must be beneficiary's reconsidered efficiant disputed annot disputed Telephone confirmediately by hand-delivered faxed notice, representative the notice and	ective, the beneficiary e such contact. htacts must be followed y either a d, mailed, e-mailed, or The beneficiary or must sign and retain send a copy of this to the health care tention in the			
	copy of the un while awaiting notice. If the treturn a signed provider must contact and surplements obtain a signal	upplier must keep a signed notice on file receipt of the signed peneficiary does not discopy, the health care document the initial absequent attempts to ture in appropriate the notice itself"			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 5 of 84

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155389	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMF 03/22	E SURVEY PLETED 2/2013	
	ROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N TIBBS AVE INDIANAPOLIS, IN 46222				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 6 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155389	B. WING		03/22/2013	
	PROVIDER OR SUPPLIER		1316 N	ADDRESS, CITY, STATE, ZIP CODE N TIBBS AVE NAPOLIS, IN 46222		
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	EDED BY FULL PREFIX (EACH C		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F000241 SS=E	in a manner and maintains or enhadignity and respector her individuality assed on observe and review, ensure a resident maintained relation as all congestion of 3 residents of 3 residents of 3 residents of CQLI [Criteriant Care] in a samand #32). Findings included the resident of the resident of the resident's and the resident and	promote care for residents in an environment that ances each resident's ct in full recognition of his y. ervation, interview, and the facility failed to ent's dignity was ated to wet clothing and on management for 2 observed who met the for Quality of Life and ple of 3 (Resident #20	F000241	(1) Nursing staff will be in-serviced regarding checking affected residents for incontinence every two hours as needed. Nursing staff will a be in-serviced regarding the resident's right to dignity. (2) Resident's MDS assessme will be used to identify other resident's with the potential to affected. (3) The DON/ADON/Evening Shift Supervisor will do rounds eve two hours for two weeks durind day shift/evening shift. The Ni Shift Supervisor will do rounds during night shift every two hours for two weeks. After that the DON/ADON will do a randoml timed round every day during shift indefinitely. The Evening Shift Supervisor will do a randomly timed round every evening during evening shift indefinitely. The Night Shift Supervisor will do a randomly timed round during night shift indefinitely. Staff that are not properly checking for incontinence and not maintain resident's dignity will be counseled and re-educated. (4) The DON/ADON will monit the corrective action by doing	and lso ents be ry g ght sours y day	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLI	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155389	A. BUILDING B. WING		03/22/2013
			_	ET ADDRESS, CITY, STATE, ZIP CODE	I
NAME OF P	PROVIDER OR SUPPLIEF	8		N TIBBS AVE	
WESTPA	RK HEALTHCARE	CENTER		ANAPOLIS, IN 46222	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	the resident ha	d a "self care deficit		rounds every two hours for tw	
	requiring prompts and cues - total to extensive assist for hygiene and			weeks during day shift/evening	
				shift. The Night Shift Supervis will do rounds during night sh	
	toileting."			every two hours for two week	
				After that the DON/ADON will	
	On 03-18-13 a	t 10:15 a.m., the		a randomly timed round every	
		bserved seated in the		during day shift indefinitely. T	he
	resident's room. Upon entrance to			Evening Shift Supervisor will	do a
		ermission of the		randomly timed round every	
				evening during evening shift	
	resident, a stro	_		indefinitely. The night shift supervisor will do a randomly	
		air. The resident's		timed round during night shift	
	•	ere observed soaked		indefinitely.	
		across the front and			
		ne pants. The resident			
	indicated, "I thi	nk I [expletive for			
	urination]." Th	e nursing staff was			
	informed of the	resident's incontinent			
	episode.				
	_	ervation on 03-21-13 at			
	•	e was a distinct urine			
	odor as the res	sident passed through			
	the dining roon	n. Certified Nurse Aide			
	_	s questioned about the			
	, ,	ntinence, and the			
		s aide indicated the			
		ot incontinent. A			
		ade to check the			
	request was in				
	residention inc	onunence.			
	During an inter	view on 03-21-13 at			
	_	CNA indicated the			
	•	ret, "it was just pee,			
	i i esidentjurine	is very strong."			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 8 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155389	B. WIN			03/22/	2013
		1	b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	3			TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER			APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΔTE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	(1)	DATE
	2. The record	for Resident #32 was				·	
	reviewed on 03-20-13 at 9:00 a.m.						
	Diagnoses incl	luded, but were not					
	_	entia, history of breast					
		ension, diabetes					
		ession and aphasia.					
		ses remained current at					
	the time of the						
		TECOIU TEVIEW.					
	The resident's	current plan of care					
	The resident's current plan of care,						
	originally dated 12-20-11, indicated						
		equired extensive to					
		Il personal care and					
	Activities of Da	ally Living."					
	During an obse	ervation on 03-19-13 at					
	8:45 a.m., the	resident was					
	transported to	the common area of					
	-	The resident had thick					
	stands of muci	us dripping from her					
		The nursing staff did					
		o assist the resident. A					
		nember walked past the					
		as alerted to the					
	resident's need						
	100100111011000						
	During an obse	ervation on 03-20-13 at					
	8:00 a.m., the						
	· ·	m her room to the					
		oom in her wheelchair.					
	I -	as observed with					
		debris" along the lower					
		•					
	lip. The nursin	•					
		ean the resident's					
	mouth/lips prio	r to the breakfast meal.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 9 of 84

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155389	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE (COMPL 03/22/	ETED
	PROVIDER OR SUPPLIER ARK HEALTHCARE CENTER	1316 N	ADDRESS, CITY, STATE, ZIP COE TIBBS AVE IAPOLIS, IN 46222	DE .	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	On 03-21-13 at 12:41 p.m., the resident was seated in the wheelchair in her room. The resident had copious amounts of mucus coming from the nares and dripping onto the blanket which had been placed across the resident's lap. 3.1-3(t)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 10 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155389	B. WING			03/22/	2013
NAME OF B	DOLUDED OD GUDDU IED		T		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P.	ROVIDER OR SUPPLIER	L		1316 N	TIBBS AVE		
	RK HEALTHCARE	CENTER			APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL	ŀ	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
F000279		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
SS=D	483.20(d), 483.20	PREHENSIVE CARE					
33-0	PLANS	REHENOIVE GARE					
		e the results of the					
		evelop, review and revise					
	the resident's con	nprehensive plan of care.					
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.						
	•	ist describe the services					
		nished to attain or maintain					
		hest practicable physical, hosocial well-being as					
		183.25; and any services					
		vise be required under					
		not provided due to the					
		e of rights under §483.10,					
		t to refuse treatment under					
	§483.10(b)(4).						
	Based on recor		F000)279	(1) Affected resident's skin she		04/16/2013
		acility failed to initiate a			will be reviewed and anyone the does not have a CP in place for		
	•	ed to compromised			compromised heels will receive		
	heels in a timel	ly manner for 1 of 2			one. Any resident receiving		
	residents review	wed in a sample of 7			Aranesp will have a CP related	d to	
	residents with	pressure ulcers and			the use of Aranesp. (2) Skin		
	failed to initiate	a care plan related to			sheets and		
		, Aranesp (antianemic)			treatment/preventative method		
		dents reviewed for			have been reviewed to identify		
		nedications (Resident			other residents with the potent to be affected. During the revie		
	#9).	(. 135.45.11			was found that consistent time		
					interventions have been put in	-	
	Findings include:				place and no other resident wa	as	
	i mangs madu	io.			found to be affected. Medication		
	1 \ Docidont #	O's record was			Records will be reviewed for of		
	1.) Resident #	a s record was			resident's receiving Aranesp th	nat	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 11 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED 03/22/2013		
		155389	B. WINC			03/22/	2013
NAME OF F	PROVIDER OR SUPPLIEF	L			ADDRESS, CITY, STATE, ZIP CODE		
WESTPA	ARK HEALTHCARE	CENTER			TIBBS AVE APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	have the potential to be affected	- d	DATE
		21/13 at 9:45 a.m. The			(3) The DON/ADON will review		
		noses included, but			skin sheets weekly and will vie		
		d to, coronary artery			skin assessments of new		
	1	tension, and Diabetic			admissions within 24 hours of		
		I. The admission Set assessment,			admission to ensure that care plans related to compromised		
		2, indicated the resident			heels are initiated in a timely		
		skin breakdown with no			manner. The facility is also him	•	
		sure ulcers indicated			a wound care nurse. Resident was admitted on 12/11/12 (no		
		petic foot ulcer. The			12/6/12) and was determined		
		ischarged on 3/19/13.			have "soft and mushy heels w		
	Toolaoni was a				peeling skin" during the		
	The admission	"Skin Check" record,			admission assessment.		
		indicated on a body			Preventative treatment was started on 12/13/12. The		
		sident's bilateral heels			DON/ADON will review MAR's	;	
	•	ushy" with skin peeling			and care plans monthly to ens		
	off of her left he				that anyone receiving Aranesp		
					has a care plan in place. (4) A instances of care plans not be		
	The "PRESSU	RE ULCER REPORT			initiated in a timely manner wil	-	
	AND OTHER S	SKIN CONDITION			reported to the Administrator a		
	REPORT" reco	ord indicated the			will be discussed during the		
	following relate	ed to the resident's			quarterly QA Meeting.		
	heels:						
	The first docun	nentation related to the					
	resident's heel	s was on 1/15/13					
	where both hee	els were indicated as					
	red with peelin	g skin with no					
	measurements	included;					
		h heels were indicated					
		eased redness but					
		areas of peeling skin					
	and no measu	rements included;					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 12 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155389	A. BUII B. WIN	LDING		03/22/	/2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	₹			TIBBS AVE		
WESTDA	RK HEALTHCARE	CENTER			APOLIS, IN 46222		
WESTER	ARK HEALTHCARE	CENTER		INDIAN	AFOLIS, IN 40222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	On 1/29/13 the	e right heel was					
	indicated as a	Stage 3 and measured					
	in centimeters	(cm) as 1.2 x (by) 0.6 x					
	0.3 with slough in the open wound bed; no information was indicated for the left heel; On 2/5/13 the right heel was indicated						
		nd measured in cm as					
		with a decrease in the					
		with a decrease in the					
	size;						
		left heel was indicated					
	_	vith no measurement					
	and described	as red with peeling					
	skin;						
	On 2/12/13 the	right heel was					
	indicated as a	Stage 3 and measured					
	in cm 4.0 x 6.0	with depth "varies;"					
		of the skin problem					
	•	ple areas of peeling					
		ations with a black spot					
		uring in cm as 0.6 x 0.4					
	x (unclear) indi	,					
		e left heel was indicated					
		n non-blanchable					
	redness and fla	aky skin;					
	On 2/19/13 the	e right heel was					
	indicated as St	tage 3 measuring in cm					
	6.0 x 7.0 with \	varying depth; the skin					
		with continued redness					
		in with "black spot					
		iii witii bidok spot					
	gone;"	المعاددة المعادية ومساوه والمعادة					
	i on 2/19/13 the	e left heel was indicated	1				I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 13 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVE	Y	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155389	B. WIN			03/22/2013	
NAME OF B	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	s		1316 N	TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	E	PLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)	D	ATE
	as a Stage 2 with no measurements indicated; the skin was described with						
		eeling skin and no					
	redness;						
	On 2/26/13 the	right heel was					
		Stage 3 and measured					
		and varied depth; the					
		ibed with 2 "slit like"					
	areas in the mi						
	non-blanchable						
		left heel was indicated					
		ith no measurement					
	_	indicated in the skin					
	description;	indicated in the 3kiii					
	description,						
	On 3/5/13 the r	ight heel was indicated					
		nd measured in cm 4.0					
	_	ng depth; the skin was					
		continued "open areas					
	within";	continued open areas					
	,	eft heel was indicated					
		ith no measurements					
	•	hable redness";					
		ilabic (Culicss ,					
	On 3/12/13 the	right heel was					
	indicated as a	Stage 3 and measured					
		with varying depth; the					
		as indicated as eschar					
		escribed as deep,					
		• •					
	_						
		-					
	as a Stage 2 at x 7.5 with less	eeding; left heel was indicated nd measured in cm 6.5 than 0.1 depth; the as indicated as					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 14 of 84

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155389			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/22/2013
	PROVIDER OR SUPPLIED		1316 N	ADDRESS, CITY, STATE, ZIP CODE TIBBS AVE IAPOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	epithelial tissudescribed as conskin.	e with the skin racked with peeling			
	1/10/13, indicated heel was tender and lateral with the right heel at pressure" to be Resident #9's were not limited.	s visit notation, dated the resident's left er and callous posterior in a pressure sore on and to use "zero oth heels in bed. care plans included, but in the following:			
	the potential for to the resident. The goal was a breakdown for and/or the next interventions with each show of any broken issues; record admission and deterioration in nurse and the turning and repair The undated in bilat (bilateral) FLOAT HEELS added to the intervine to the termine to the	dated 12/21/12, was or skin breakdown due is impaired mobility. To not have skin the duration of her stay it 90 days. The were skin check sheets wer, notify charge nurse areas of skin or skin skin assessment upon weekly; report any in skin integrity to charge physician; assist with positioning as needed. Intervention to "elevate legs when in bed. S - NSG (nursing)" was interventions with a liter to float heels written.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 15 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155389		(X2) MULTIPLE A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 22/2013	
	PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP S N TIBBS AVE ANAPOLIS, IN 46222	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	ulcer on the lef	the Stage 2 pressure It heel and the care age 3 pressure ulcer on were both initiated on				
	interview LPN wound nurse, i should had bee	8:55 a.m., during an #19, the designated ndicated a care plan en initiated when neels were indicated as				
	provided by the Nursing) on 3/2	FUS ULCERS SORES)" policy was e DON (Director of 22/13 at 10:10 a.m. olicy indicated the				
	pressure sores treatment to pr	residents having will receive necessary omote healing, prevent developing, and on.				
	resident carepl condition. This location and st 6. Intervention	s to be made on the an relative to skin s entry should include				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 16 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155389		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 03/22/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE TIBBS AVE APOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	ULCERS (BED provided by the 3/22/12 at 10:1 policy indicated "RECOGNIZ SIGNS/SYMPT PRESSURE SITE SIGNS/SYMPT PRESSURE SITE SITE SITE SITE SITE SITE SITE SIT	ING THE TOMS OF A ORE: first signs of a bedsore resident's skin are: ened areas; A feeling of burning at emfort;" #9's record was 21/13 at 9:45 a.m. The noses included, but d to, anemia, coronary hypertension, and Kidney Disease). write physician's order, e, indicated the er was Darbepoetin b) 60 mcg nject subcutaneously 1 order, dated 1/25/13,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 17 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155389	B. WING		03/22/2013
NAME OF P	PROVIDER OR SUPPLIEI	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	
				TIBBS AVE	
WESTPA	RK HEALTHCARE	CENTER	INDIAN	IAPOLIS, IN 46222	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	_	rview on 3/21/13 at			
	•	#5 indicated the drug			
		d by the nursing staff			
		rug Guide for Nurses			
		ITION." This reference			
		epoetin (Aranesp) was			
		n "antianemics" and			
		for anemia associated			
		nal failure. The			
		ations indicated the			
	following:				
	· ·	e should be monitored			
	before and dur				
	•	nse for symptoms of			
		ıe, dyspnea, pallor];			
	Hemoglobin sh	nould be monitored;			
	Monitor as me	dication could increase			
		of life-threatening			
	cardiovascular	complication, cardiac			
	arrest, neurolo	gic events (seizures,			
	stroke), hypert	ensive reactions,, CHF,			
	vascular				
	thrombosis/isc	hemia/infarction, acute			
	MI , and fluid c	overload/edema.			
	No care plan w	vas indicated related to			
	the use of Arei	nesp.			
	3.1-35(a)				
			1	I .	I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 18 of 84

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155389	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	E SURVEY PLETED 2/2013		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N TIBBS AVE INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR. (EACH CORRECTIVE ACTION SECONDS-REFERENCED TO THE ADEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 19 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
		155389	A. BUII B. WIN			03/22/	2013
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER			APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000282 SS=E	483.20(k)(3)(ii) SERVICES BY Q CARE PLAN The services provide facility must be propersons in accord written plan of care dependent on the service of the ser	vided or arranged by the ovided by qualified lance with each resident's re. rvation and record ity failed to ensure of care and physician lowed for 5 of 35 met the CQLI [Criteria ife and Care] related ders and plans of care r, 49, 20, 9 and 35). e: or Resident #32 was 8-20-13 at 9:00 a.m. uded but were not entia, history of breast ension, diabetes ession and aphasia. es remained current at record review.	F00	0282	Resident's with skin breakdow with the potential for further sk breakdown due to impaired mobility will have a pressure relieving cushion in their wheelchair. All resident's current have pressure relieving mattresses. A new wheelchair has been ordered for resident 49 to assist with proper positioning. Residents will continue to be checked every hours and as needed for incontinent episodes. All of the referenced residents have no she breakdown. All resident's receiving the medication Arans will have a care plan related to use. If telephone consent is obtained for ABN, a copy of the notice will be sent via mail with return receipt requested. The (1) receipt will be attached to ABN notice for retention in the file. In regards to resident #35, the order to monitor weekly blopressure and pulse was written on 3/21/13. There was no bloopressure and pulse recorded of 3/20/13 because the order had not yet been written. We will continue to monitor blood	n in ntly # two e skin sep oits e n the nod n don d	04/16/2013
	chair cushions. repositioning in	Encourage chair every 1-2 hours			pressure and pulse as ordered the physician. (2) MDS assessments will be reviewed		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 20 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLE	ETED
		155389	A. BUII B. WIN			03/22/2	2013
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8					
WESTDA	RK HEALTHCARE	CENTED			TIBBS AVE APOLIS, IN 46222		
WESTFA	ARK HEALTHCARE	CENTER		INDIAN	AFOLIS, IN 40222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
IAU	During continuous-20-13 from a.m., the reside wheelchair. The have an anti-present of the wheelchair action of care, indicated the resident of care include as needed successive.	ous observations on 8:09 a.m. until 11:00 ent was seated in the ne resident did not ressure device on the elchair. for Resident #49 was 3-20-13 at 9:00 a.m. uded but were not ity, cerebral vascular rtension, anemia, skin graft left arm, hemiplegia and 2nd These diagnoses ent at the time of the dated 01-17-13, esident had the kin breakdown due to ity, incontinence and erventions to this plan d "positional devices h as pillows, chair ourage repositioning in		IAU	ensure that residents with potential for skin breakdown do impaired mobility have pressure relieving cushions in their wheelchairs. MAR's and care plans will be reviewed to ensure that any resident received. Aranesp has a care plan related to its use. (3) Resident's with the potential for skin breakdown do to impaired mobility will have a pressure relieving cushion in the wheelchair. All resident's receiving Aranesp will have a care plan related to its use. If telephone consent has been obtained for ABN, an attempt wheelchair accompany of the notice with return receipt requested. The DON/ADON will review skin sheets, treatments/preventative methods, and care plans week to ensure that proper care plan are in place and being followed. Medication records a care plans will be reviewed monthly to ensure that all resident's receiving Aranesp has care plan related to its use. Administrator will monitor the procedure with the ABN notice weekly at the Medicare Meeting	ving ed he ue a heir will by th e kly hs and ave The	DATE
	dysphagia "due cerebral vascu risk for aspirati	originally dated ated the resident had e to late effects of lar accident and at high on." Interventions to e included "have					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPL	ETED
		155389	B. WIN			03/22/	2013
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			TIBBS AVE		
WESTPA	ARK HEALTHCARE	CENTER			APOLIS, IN 46222		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES		ID	, -		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Iname of reside	ent] in upright position					
	-	nd keep [name of					
	resident] in upright position at least 30 minutes after each meal or receiving liquids." During an observation on 03-19-13 at 7:50 a.m., the resident was seated in						
	1	eelchair on 03-19-13 at					
	_	ne assist dining room.					
		aff provided the					
		I to the resident, and					
		mained in the reclined					
	position. Durin	_					
		03-19-13 at 10:46					
		m. and again at 1:05					
	-	ent remained seated in					
	1	heelchair without a					
		e and without being					
	positioned upri	ight after meal service.					
	D. min at a second						
	_	ervation on 03-20-13 at					
	· · · · · · · · · · · · · · · · · · ·	resident was seated in					
		in the assist dining					
		ident was in a reclined					
	•	folded sheet place					
		ident's neck/head. At					
		resident was moved to					
	_	and at 9:10 a.m.					
	moved to the r	esident's room. The					
	resident remai	ned in the reclining					
	wheelchair witl	hout a position change					
	at 11:20 a.m.	The Certified Nurse					
	Aide indicated	she "got the resident					
		ot to work in the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 22 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155389	B. WIN	G		03/22/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	NO VIDEN ON BOTTEIEN				TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER		INDIAN.	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	morning around	d 7:00 a.m."					
	During an obsedining room on the resident was wheelchair in the The resident was position by the Upon completion resident was transfer toom and remained in satisfactory. During an obsedining room on p.m. the reside (Qualified Median reclined position) During an obsedining an obsedining an obsedining room on p.m. the reside (Qualified Median reclined position) During an obsedining an obsedining room on p.m., Certand #20 transfer the wheelchair	ervation in the assist 03-21-13 at 8:14 a.m., as seated in the ne reclined position. as fed in the reclined Certified Nurse Aide. on of breakfast the ansported back to the ained seated in the nout a change in :24 a.m., the resident me position. ervation in the assist 03-21-13 at 12:40 nt was fed by the QMA ication Aide) in a					
	indicated it was	s the first time the een laid down since					
	breakfast.						
	reviewed on 03 Diagnoses incl	for Resident #20 was 3-19-13 at 8:00 a.m. uded but were not d dementia, seizure					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 23 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPL	ETED
		155389	B. WIN			03/22/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	£		1316 N	TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
	disorder, diabetes mellitus, and hypertension. These diagnoses remained current at the time of the record review.						
	data set asses indicated the reincontinent of the series originally dated the resident has requiring prom	resident's minimum sment, dated 02-14-13, esident was "always powel and bladder." current plan of care, di 11-23-12, indicated and a self care deficit pts and cues - total to st for hygiene and					
	resident was o resident's room the room, by poresident, a stropermeated the sweat pants we moisture acrosslegs of the panindicated, "I this urination]." Th	t 10:15 a.m., the bserved seated in the n. Upon entrance to ermission of the ong urine odor air. The resident's ere soaked with as the front and upper tts. The resident nk I [expletive for e nursing staff was e resident's incontinent					
	1:00 p.m., ther odor as the res	ervation on 03-21-13 at e was a distinct urine sident passed through n. Certified Nurse Aide					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 24 of 84

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155389	A. BUILDING	00	03/22/2013
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	l .		TIBBS AVE	
	ARK HEALTHCARE	CENTER	INDIAN	IAPOLIS, IN 46222	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
TAG	(CNA) #18 was resident's incordertified nurses resident was more request was more request was more resident for incomparity of the sident was wore resident was wore resident was wore resident was wore resident's diagram were not limited disease, hyper Mellitus Type II Kidney Disease The signed reword dated 12/12/12 physician's ord Alpha (Aranesp (micrograms) in time a week. A physician ord indicated. " Ara (micrograms) in (under the skin hemoglobin is got a physician ord).	s questioned about the ntinence, and the saide indicated the ot incontinent. A ade to check the ontinence. View on 03-21-13 at CNA indicated the ret, "it was just pee, is very strong." D's record was reviewed of the noses included, but do, coronary artery tension, Diabetic I and CKD (Chronic e). View on 03-21-13 at CNA indicated the ret, "it was just pee, is very strong." O's record was reviewed of the noses included, but do to, coronary artery tension, Diabetic I and CKD (Chronic e). Virite physician's order, e, indicated the re was Darbepoetin of the one of the noses included the ret was Darbepoetin of the noses included the nose	TAG	DEFICIENCY	
	subcutaneously	v everv month starting			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 25 of 84

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	LE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	
		155389	B. WING			03/22/	2013
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
\\/EOTD		CENTED			TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER	INL	JIANA	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAC	'	DEFICIENCY)		DATE
	on 2/28/13."						
	The Medication	n Administration					
	Record indicate	ed the following:					
	On 12/10/12 A	ranesp was not given.					
		icated the Hemoglobin					
	was 10.7 but di	<u> </u>					
		er for omission related					
		in laboratory (lab) test					
	result on that d	• • •					
	Toodit on that a	ato.					
	On 1/31/13 Ara	nesp was not given.					
		not indicate a reason					
		was not given. A					
		o result, dated 1/14/13,					
	indicated a low						
		nedication should have					
	been given (pe						
	physician's ord	er).					
	-						
		anesp was no given.					
	The record indi	cated the medication					
	was not availat	ole. The Hemoglobin					
		d 2/28/12, was 9.7					
	(low), indicating	g the medication					
		een given (per the					
	1/25/13 physici	an's order).					
	0 0/00//0 :	40.0 5					
		10:25 a.m., during an					
	· ·	Director of Nursing					
	, ,	d there was no hold					
		the hemoglobin for					
		, Aranesp, prior to the					
	1/25/13 physici	an's order.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 26 of 84

SUMMARY S			ADDRESS CITY STATE ZIP CODE				
	WESTPARK HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N TIBBS AVE INDIANAPOLIS, IN 46222				
*	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION			
interview, the E pharmacy did r medication, Are	OON indicated the not always send the enesp, until the						
interview, the fa a telephone co (Advance Bene Noncoverage) an attempt to o responsible par 1 telephone co	acility failed to ensure nsent for ABN eficiary Notice of was followed up with btain the resident's rty's signature for 1 of onsent in a sample of 3 coverage reviews.						
Resident #36's non-coverage v 3/21/2013. This resident on 10/wasn't understa This same recorresident's respondified via teleday (10/15/12), was obtained.	notice for Medicare was reviewed on s record indicated the 15/12 "refused to sign, anding the notice" ord also indicated the consible party was phone on this same and a phone consent						
	On 3/22/13 at 3 interview, the E pharmacy did repharmacy revies a telephone contices of non-(Resident #36) Findings include Resident #36's non-coverage varies and the same recording to the same reco	Findings included: Resident #36's notice for Medicare non-coverage was reviewed on 3/21/2013. This record indicated the resident on 10/15/12 "refused to sign, wasn't understanding the notice" This same record also indicated the resident's responsible party was notified via telephone on this same day (10/15/12), and a phone consent	On 3/22/13 at 3:25 p.m., during an interview, the DON indicated the pharmacy did not always send the medication, Arenesp, until the pharmacy reviewed the hemoglobin. Based on record review and interview, the facility failed to ensure a telephone consent for ABN (Advance Beneficiary Notice of Noncoverage) was followed up with an attempt to obtain the resident's responsible party's signature for 1 of 1 telephone consent in a sample of 3 notices of non-coverage reviews. (Resident #36) Findings included: Resident #36's notice for Medicare non-coverage was reviewed on 3/21/2013. This record indicated the resident on 10/15/12 "refused to sign, wasn't understanding the notice" This same record also indicated the resident's responsible party was notified via telephone on this same day (10/15/12), and a phone consent was obtained.	On 3/22/13 at 3:25 p.m., during an interview, the DON indicated the pharmacy did not always send the medication, Arenesp, until the pharmacy reviewed the hemoglobin. Based on record review and interview, the facility failed to ensure a telephone consent for ABN (Advance Beneficiary Notice of Noncoverage) was followed up with an attempt to obtain the resident's responsible party's signature for 1 of 1 telephone consent in a sample of 3 notices of non-coverage reviews. (Resident #36) Findings included: Resident #36's notice for Medicare non-coverage was reviewed on 3/21/2013. This record indicated the resident on 10/15/12 "refused to sign, wasn't understanding the notice" This same record also indicated the resident's responsible party was notified via telephone on this same day (10/15/12), and a phone consent was obtained.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 27 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155389	B. WIN			03/22/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	· ·		1316 N	TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		Social Service Director					
	indicated she did a phone approval						
		ut did not follow up with					
	a signed conse	ent.					
		MENT OF HEALTH					
		SERVICES Centers for edicaid Services					
		edicaid Services n," dated April 2011,					
		•					
	ABN's:	ollowing related to					
	ADIN 5.						
	 " When delive	ery is not in-person, the					
		e documented in the					
	beneficiary's re						
		ective, the beneficiary					
	cannot dispute						
		ntacts must be followed					
	immediately by						
		l, mailed, e-mailed, or					
		The beneficiary or					
		must sign and retain					
	· •	send a copy of this					
		to the health care					
	provider for ret						
	beneficiary's re						
	Deficitionary 3 le	Jouru.					
	The provider/s	upplier must keep a					
	<u>-</u>	signed notice on file					
		receipt of the signed					
		peneficiary does not					
		copy, the health care					
		document the initial					
	l •	bsequent attempts to					
		ture in appropriate					
	Obtain a Signat	ure in appropriate					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 28 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155389		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/22/2013		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	•	
WESTPA	RK HEALTHCARE	CENTER	1316 N TIBBS AVE INDIANAPOLIS, IN 46222			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	records or on the	ne notice itself"				
	3.1-4(f)(3)					
	at 10:00 a.m., I observed in his television. The was "sleepy."	ervation on 03/21/2013 Resident #35 was s room watching e resident indicated he				
	on 03/21/13 at included, but w	record was reviewed 10:15 a.m. Diagnoses ere not limited to, us and hypertension ssure).				
	A care plan, da indicated, ",,,m signs)"	ited 11/06/2012, onitor VS (vital				
	indicated blood	rder, dated 03/21/13, I pressure and pulse een monitored weekly s.				
	A treatment flo	w sheet indicated the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 29 of 84

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155389	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/22/2013
	ROVIDER OR SUPPLIER RK HEALTHCARE CENTER	1316 N	ADDRESS, CITY, STATE, ZIP CODE TIBBS AVE APOLIS, IN 46222	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
	blood pressure was not monitored on Wednesday, 03/20/2013.			
	3.1-35(g)(2)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 30 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155389	B. WIN			03/22/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			TIBBS AVE		
MESTDA	RK HEALTHCARE	CENTED			IAPOLIS, IN 46222		
WESTEA	IRK HEALTHCARE	CENTER		INDIAN	NAPOLIS, IN 40222		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000309	483.25						
SS=D	PROVIDE CARE	SERVICES FOR					
	HIGHEST WELL						
		ist receive and the facility					
	•	necessary care and					
		or maintain the highest					
	practicable physic						
		l-being, in accordance with					
	the comprehensive care.	ve assessment and plan of					
		ervations, interview, and	F00	0309	(1) For all dialysis patients the		04/16/2013
		the facility failed to	1 00	0307	dialysis port dressing will be		04/10/2013
		•			assessed each shift for		
		aluate a dialysis			placement, blood, and/or		
	•	eturn to the facility for			drainage. The patient will be		
	1 of 1 resident	reviewed for dialysis			assessed for pain. This will be		
	(Resident #127	7) in a sample of 3			documented on the MAR. Upo	n	
	dialysis resider	nts and failed to ensure			return from dialysis the patient		
	•	2 of 3 residents			and port site will be assessed		
		ositioning in a sample			well. These assessments will be	oe	
	-	ts #32 and #49).			documented on the medical		
	oi so (Residen	15 #32 and #49).			record. This was being done		
					before, but was not being documented properly. Resider	. +	
	Findings includ	le:			#32 has a pressure relieving	IL	
					cushion in her wheelchair. A n	ew.	
	 The record 	for Resident #32 was			wheelchair to assist in position		
	reviewed on 03	3-20-13 at 9:00 a.m.			has been ordered for resident	•	
	Diagnoses incl	uded but were not			49. (2) Resident's MDS		
	_	entia, history of breast			assessments will be reviewed	to	
		ension, diabetes			identify other resident's with th	е	
					potential to be affected. (3) All		
	•	ssion and aphasia.			residents with the potential for		
	_	es remained current at			further skin breakdown as a re		
	the time of the	record review.			of impaired mobility will have a		
					pressure relieving cushion in the		
	A plan of care	originally dated			wheelchair. All dialysis patients		
		ated the resident had			will have their port site dressin assessed each shift and upon	y	
	the potential fo				return from dialysis. The patier	nt	
	•				will be assessed for		
		e to impaired mobility			pain/discomfort each shift and		
	and incontinen	ce. Interventions to			Familiano Common Carrier		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 31 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLI	ETED
		155389	A. BUI B. WIN	LDING		03/22/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
WEOTOA		CENTED			TIBBS AVE		
WESTPA	ARK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	this plan of car	e included positional			upon return from dialysis. (4)	The	
	devices as nee	eded such as a pillow,			DON/ADON will review		
	chair cushions	•			documentation for dialysis	_	
		n chair every 1-2 hours			patients on every dialysis day		
		Terrain every 1-2 mours			one week, then once a week for		
	Dumin or 4!				one week, and after that mont The DON/ADON will review ca	-	
	_	ous observations on			plans monthly to ensure that	11.0	
		8:09 a.m. until 11:00			residents with the potential for		
		ent was seated in the			further skin breakdown due to		
	wheelchair. Th	ne resident did not			impaired mobility have pressur		
	have an anti-pi	ressure device on the			relieving cushions in their		
	seat of the whe	eelchair.			wheelchairs.		
	2 The record	for Resident #49 was					
		3-20-13 at 9:00 a.m.					
		uded but were not					
		ity, cerebral vascular					
	accident, hype	rtension, anemia,					
	osteoarthritis, s	skin graft left arm,					
	dysphasia, left	hemiplegia and 2nd					
		These diagnoses					
	_	ent at the time of the					
	record review.	on at the time of the					
	i iecolu leview.						
	A miss of	data d 04 47 40					
	'	dated 01-17-13,					
		esident had the					
	potential for sl	kin breakdown due to					
	impaired mobil	ity, incontinence and					
	•	erventions to this plan					
		d "positional devices					
		h as pillows, chair					
		-					
		ourage repositioning in					
	chair every 1 -2	2 nours."					
	A plan of care,	originally dated					
	01-17-13, indic	cated the resident had					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 32 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155389	B. WIN	G		03/22/2	2013
NAME OF F	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					TIBBS AVE		
WESTPA	ARK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e to late effects of					
		lar accident and at high					
	•	on." Interventions to					
	•	e included "have					
	1 -	ent] in upright position					
		nd keep [name of					
		right position at least 30					
		each meal or receiving					
	liquids."						
	During on ohoo	orgation on 02 10 12 of					
	_	ervation on 03-19-13 at					
	· ·	resident was seated in elchair on 03-19-13 at					
		ne assist dining room.					
		_					
	1	aff provided the					
		to the resident, and					
		mained in the reclined					
	position. During	g continuous i 03-19-13 at 10:46					
		n. and again at 1:05					
	· ·	•					
	•	ent remained seated in					
		heelchair without a					
		e and without being					
	positioned upri	ght after meal service.					
	During an obse	ervation on 03-20-13 at					
	_	resident was seated in					
	· ·	in the assist dining					
		ident was in a reclined					
		folded sheet placed					
		dent's neck/head. At					
		esident was moved to					
		and at 9:10 a.m.					
	1	esident's room. The					
	i resident remaii	ned in the reclining					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 33 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	ETED
		155389	B. WIN			03/22/	2013
NAME OF B			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	L		1316 N	TIBBS AVE		
WESTPA	ARK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		nout a position change					
		The Certified Nurse					
		she "got the resident					
	up when she g	ot to work in the					
	morning around 7:00 a.m."						
	During an obse	ervation in the assist					
		03-21-13 at 8:14 a.m.,					
	. •	as seated in the					
	wheelchair in t	he reclined position.					
		as fed in the reclined					
		Certified Nurse Aide.					
	l '	on of breakfast the					
		ansported back to the					
		ained seated in the					
		nout a change in					
	l ·	:24 a.m., the resident					
	remained in sa	me position.					
	During an obse	ervation in the assist					
	dining room on	03-21-13 at 12:40					
	p.m. the reside	nt was fed by the QMA					
	·	ication Aide) in a					
	,	on. A sheet was					
	· •	d up and placed behind					
		nead. The residents					
		bserved off of the foot					
		ng to the side of the					
	_	1:10 p.m. the resident					
	remained in wh	•					
	I —	arm/hand dangled to					
		f the wheelchair. The					
		was hyperextended					
	and a sheet wa	as folded and placed					
	behind the resi	dent's head.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 34 of 84

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155389		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/22/2013
	PROVIDER OR SUPPLIEI		1316 N	ADDRESS, CITY, STATE, ZIP CODE TIBBS AVE IAPOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NOT MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	1:30 p.m., two transferred the wheelchair to be observation the indicated it was resident had be she prepared to breakfast in the 3. On 3/20/13 interview RN ##127's schedu Monday, Wedreach week. So resident's right was not cleare a permanent of left claviclular and comparts of the prepared of the indicated the indicated the indicated the indicated of the prepared	at 9:01 a.m., during an at 9:02 and Friday of the indicated the at upper forearm fistula at to use, and she had atheter located in her area for use at dialysis. 9:36 a.m., during an at 9:20 a.m., during an at 9:40 a.m., during an at 9:40 a.m., during an at 9:50 a.m., during an 9:50 a.m.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 35 of 84

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155389	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/22/2013
	PROVIDER OR SUPPLIER	1316 N	ADDRESS, CITY, STATE, ZIP CODE TIBBS AVE APOLIS, IN 46222	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	order/direction to assess the resident's dialysis access site, the information should have been documented in the nurses notes.			
	Resident #127's record was reviewed on 3/21/13 at 9:50 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease.			
	The nurse's notes from 3/8/13 at 6 p.m. to 3/20/13 at 11:00 a.m. lacked documentation to indicate the dialysis access site was assessed on 3/8/13, 3/9/13, 3/10, 13, 3/12/13, 3/15/13, 3/16/13, 3/17/13, and 3/19/13.			
	The policy for monitoring a resident's dialysis port was provided by the Director of Nursing on 3/21/13 at 2:30 p.m. This current policy indicated the following:			
	"It is the policy of Westpark Healthcare to monitor the Dialysis Port dressing for dialysis patients each shift"			
	3.1-37(a)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 36 of 84

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2013 FORM APPROVED OMB NO. 0938-0391

	ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 155389 A. BUILDING B. WING		00	COMPLETED 03/22/2013			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N TIBBS AVE INDIANAPOLIS, IN 46222				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 37 of 84

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155389	B. WIN			03/22/	2013
			В. WПV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				TIBBS AVE		
WESTPA	ARK HEALTHCARE	CENTER			APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000314 SS=E	PRESSURE SOF Based on the con a resident, the fact resident who enter pressure sores do sores unless the it condition demons unavoidable; and sores receives neservices to promoting to the developing. Based on record and interview, the ensure pressure assessed and it alternative previmplemented a provided to presidents review ulcers. (Resident #9, #Findings included to the president of the previous formula of	Inprehensive assessment of cility must ensure that a sers the facility without been not develop pressure individual's clinical strates that they were a resident having pressure excessary treatment and one healing, prevent went new sores from a review, observation, the facility failed to be areas were monitored timely with wentive measures and incontinent care event potential skin a resident observed in a resid	F00	0314	(1)The DON/ADON will review the affected resident's skin sheets and treatments to determine if the skin condition being treated appropriately. The DON/ADON will also assess a measure any current wounds a ensure that measurements on skin sheets are accurate. The DON/ADON will do rounds to ensure that appropriate preventative measures are being completed as ordered. The DON/ADON will also do round ensure that appropriate incontinent care is being provided. (2) The DON/ADON complete skin checks on each current resident to ensure that current skin sheets are accura and the treatments appropriate order to identify any other residents that could potentially affected. (3) A new wound carnurse is being hired. A wound care team consisting of the Administrator, Asst. Administrator, DON,	is are and the the sto will the te, in be	04/16/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 38 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		155389	B. WIN			03/22/2013	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER			APOLIS, IN 46222		
	INTILALITICANE	CLIVIEN		INDIAN	AI OLIO, III 40222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		N
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	The "NORTON	I PLUS PRESSURE			ADON, Wound Nurse, and		
	ULCER SCALE	∃," dated 12/11/12,			Medical Director has also been	٦	
	indicated the total score was 16 with a total score of 10 or less equaled a				established and will be doing weekly wound rounds. Within	24	
					hours of admission the	24	
		"TOTAL NUMBER OF			DON/ADON or wound nurse w	rill	
	_	(S" of "3" was to be			be reviewing new admission s		
					sheets and ensuring that they	•	
	deducted from the "NORTON SCALE SCORE" of 16 resulting in an actual total score of 13, not 16. No further				accurate and have appropriate	•	
					treatments/preventative		
		·			measures ordered. (4) The		
		s indicated on this			wound care team will be doing	•	
	record.				rounds weekly in order to ensu		
					that wounds are being properly documented and treated.Resu	•	
	The admission	"Skin Check" record,			of the rounds will be discussed		
	dated 12/6/12.	indicated on a body			quarterly in QA. The		
		sident's bilateral heels			DON/ADON/Evening Shift		
	_	ushy" with skin peeling			Supervisor will do rounds ever	y	
	off of her left he				two hours for two weeks during	g	
		cc i.			day shift/evening shift. The Ni		
	TI "DDE0011				Shift Supervisor will do rounds	•	
		RE ULCER REPORT			during night shift every two ho	urs	
		SKIN CONDITION			for two weeks to ensure that		
	REPORT" reco	ord indicated the			positioning of residents and incontinent care are being dor		
	following relate	ed to the resident's			every two hours and as neede		
	heels:				After the initial two weeks the	u.	
					supervisor on each shift will do	ра	
	The first docun	nentation related to the			randomly timed round on each		
		s was on 1/15/13			shift indefinitely. During these		
		els were indicated as			rounds, preventative		
					measures, such as floating hee		
	red with peelin	~			will also be checked to ensure		
	measurements	s included;			that they are being done.		
		th heels were indicated					
	as having decreased redness but						
	continued with	areas of peeling skin					
		rements included;					
		•					
			- 1			1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 39 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155389		A. BUILDING 00 COM		(X3) DATE SURVEY COMPLETED 03/22/2013	
	PROVIDER OR SUPPLIEF ARK HEALTHCARE		1316 N	TIBBS AVE IAPOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
140	On 1/29/13 the indicated as a in centimeters 0.3 with slough bed; no informathe left heel;	e right heel was Stage 3 and measured (cm) as 1.2 x (by) 0.6 x in the open wound ation was indicated for	IAU		DATE
	as a Stage 3 a 1.0 x 0.5 x 1.1 size; On 2/5/13 the as a Stage 2 w	right heel was indicated nd measured in cm as with a decrease in the left heel was indicated with no measurement as red with peeling			
	indicated as a in cm 4.0 x 6.0 the description indicated multi skin and ulcera necrosis meas x (unclear) indicated on 2/12/13 the	e left heel was indicated n non-blanchable			
	indicated as St 6.0 x 7.0 with v was described and peeling sk gone;"	e right heel was tage 3 measuring in cm varying depth; the skin with continued redness in with "black spot			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 40 of 84

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155389	B. WIN			03/22/	2013
			В. W II.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	S. C.			TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER			APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated; the s	ith no measurements skin was described with eeling skin and no					
	in cm 4.0 x 6.0 skin was descr areas in the mi non-blanchable On 2/26/13 the as a Stage 1 w	Stage 3 and measured and varied depth; the ibed with 2 "slit like" ddle of the					
	as a Stage 3 at x 6.0 with varying described with within"; On 3/5/13 the It as a Stage 1 when and "non bland on 3/12/13 the indicated as a sin cm 6.5 x 7.5 "tissue type" when with the skin decracked and blue on 3/12/13 the as a Stage 2 at x 7.5 with less	Stage 3 and measured with varying depth; the as indicated as eschar escribed as deep,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 41 of 84

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155389	B. WING		03/22/2013
NAME OF P	PROVIDER OR SUPPLIEI	3		T ADDRESS, CITY, STATE, ZIP CODE N TIBBS AVE	
WESTPA	ARK HEALTHCARE	CENTER		N TIBBS AVE NAPOLIS, IN 46222	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
1710	epithelial tissu	,	1710		DATE
	described as c	racked with peeling			
	skin.				
	No further info	rmation of the			
		s was indicated in the			
	nurse's notes related to the resident's				
		from 12/7/12 to			
	3/21/13.				
	The physician'	s visit notation, dated			
		ted the resident's left			
	heel was tende	er and callous posterior			
		n a pressure sore on			
	~	and to use "zero			
	l •	oth heels in bed. The			
		imum Data Set			
	· ·	ated 12/18/12, esident's Basic			
		tal Status's score was			
	11 with a score				
		The resident was at			
		eakdown with no			
	unhealed pres	sure ulcers indicated			
	and with a diat	petic foot ulcer.			
	The physician'	s orders were as			
	follows:				
	On 12/13/12 th	ne order was to wash			
	BLE (bilateral	lower extremities) with			
	mild soap and	water, pat dry and			
	'''	to skin including heels			
	I	kerlix and change			
	every day;				
	On 12/27/12 th	ne order was to clean			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 42 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	ETED
		155389	B. WIN			03/22/2	2013
NAME OF B	DROWNER OF GUIDNI IED		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1316 N	TIBBS AVE		
WESTPA	ARK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		and water, pat dry and					
	'''	to left leg and foot bid					
	` <i>* ′</i>	and leave open to air;					
	l –	leg and foot in its					
	1	asolex, cover 2 open					
		e and wrap with kerlex					
	bid and prn (as	· · · · · · · · · · · · · · · · · · ·					
		order was to continue					
		to BLE and elevate					
	bilateral legs when in bed "FLOAT						
	HEELS";						
	On 1/10/13 the order was "zero						
	pressure" to bilateral heels while in						
	bed - off load w	•					
		order was to cleanse					
		soap and water,					
	Vasolex or an	equivalent to open					
	areas and telfa	, kerlix every day;					
	On 1/30/13 the	order was to					
	discontinue (d/	c) the Vasolex to the					
	right heel bid a	nd prn; clean open					
	area of the righ	it heel with normal					
	saline, apply sa	antyl to wound bed,					
		ge and wrap with					
	kerlex; change	daily and prn; d/c telfa					
	and kerlex to B	LE - continue with the					
	Vasolex;						
	On 2/6/13 the o	order was to d/c the					
	orders to eleva	te heels; d/c previous					
	treatment to the	e right heel; start:					
	apply Vasolex	to bilateral heels and					
	cover with gau	ze and wrap with kerlex					
	and change bid	d; elevate BLE on 2					
	pillows at all tin	nes when in bed and					
	hang heels ove	er the edge of pillows;					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 43 of 84

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		155389	B. WING			03/22/	2013
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1316 N	TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER			APOLIS, IN 46222		
(VA) ID	CIDOLADVC	TATEMENT OF DEPLOYENCIES			, -		(37.5)
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		*		IAG	BELLEER		DATE
		e order was to apply					
		foot and leg; cover with					
	gauze and loosely wrap with kerlex; apply Vasolex to right foot and leg						
	bid;						
	On 3/1/13 the order was to d/c						
	treatment to right foot and leg; start: wash right leg and foot with soap and water; apply Santyl to open areas and Vasolex to remainder of foot and heel, cover with gauze and wrap with						
	· ·						
	kerlex, change daily;						
	On 3/8/13 the order was a left foot						
		d a right foot diabetic					
	shoe;						
	On 3/18/13 the	e order was to d/c all					
	previous treatn	nent orders; apply thick					
	layer of Vasole	ex to left heel; wash					
	right leg and fo	oot with soap and					
		antyl to the 3 open					
		apply Vasolex to					
		ght foot and heel,					
		_					
	_	ze and wrap with					
	kerlex.						
		8:15 a.m., during an					
	interview LPN	#19 indicated she did					
	the wound dres	ssings throughout the					
	week and state	ed she "was a phone					
		he weekends. She					
	1	vening nurse provided					
		e on weekends.					
	and wound care	on weekends.					
	On 2/24/42 at 1	2:20 p.m. during on					
		2:20 p.m., during an					
	interview, KN #	#5 indicated Resident					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 44 of 84

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILDING	00	COMPLETED
		155389	A. BUILDING B. WING		03/22/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	R		TIBBS AVE	
WESTP	ARK HEALTHCARE	CENTER		IAPOLIS, IN 46222	
	1			171 0010, 111 40222	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG	†	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		y compliant in keeping			
		f the bed when she was			
	in bed. RN #5	also indicated she had			
	special shoes and thought those				
	shoes contributed to the resident's				
	heels breakdown.				
	On 3/22/13 at	8:55 a.m., during an			
	interview LPN #19 indicated wound				
		s should have been			
		She also indicated with			
	soft and mushy heels a preventive				
	·	•			
		d have been to keep			
		neels off of the bed.			
		Resident #9 would not			
		place to keep her			
		bed with her short			
		so a gel pillow was			
	tried. The resi	dent complained the			
	gel pillow limite	ed her movement too			
	much in bed, s	o the gel pillow was no			
	longer used. L	PN #19 indicated the			
	_	ive waffle boots from			
		ut she would not keep			
		#19 indicated, with soft			
		els, the resident's heels			
	1	en floated initially, and			
		vould have been used.			
	lilen vasolex v	vould have been used.			
	2 The record	for Resident #53 was			
		3-22-13 at 10:00 a.m.			
	-	uded, but were not			
	limited to, cogr				
		otension, loss of			
	weight, cerebro	ovascular disease,			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 45 of 84

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155389	B. WING		03/22/2013
NAME OF P	PROVIDER OR SUPPLIE	R	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				TIBBS AVE	
WESTPA	RK HEALTHCARE	CENTER	INDIAN	APOLIS, IN 46222	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		entia, hypertension, and			
	1	ary tract infection.			
	These diagnoses remained current at the time of the record review.				
	tne time of the	record review.			
	Review of the Norton plus pressure				
	ulcer scale, dated 10-11-12, indicated the resident had a score of "14" with				
		ondition, alert mental			
		with help, mobility			
		and occasionally			
		he assessment			
		ore of 10 or greater			
		esident at high risk for			
	pressure ulcer	S.			
	The Norton blu	us pressure ulcer scale			
		lated 01-11-13,			
	· ·	esident's score was "8"			
		nysical condition,			
	· ·	tal state, chair bound,			
		mited and had double			
	incontinence.	חוונכט מווט וומט טטטטוכ			
	moontinence.				
	The Norton pli	us pressure ulcer scale			
		lated 02-21-13,			
	·	esident's score was "7"			
		physical condition, was			
	1	irbound, very limited			
		ouble incontinence.			
	incoming and di	Cable international.			
	Review of the	resident's current plan			
		02-18-13, indicated the			
		red assist from staff with			
		positioning due to			
			1	I	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 46 of 84

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		155389	B. WING			03/22/	2013
NAME OF P	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
WESTPA	RK HEALTHCARE	CENTER			TIBBS AVE APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	lity. Interventions					
		erve skin daily and					
	record/report any new broken areas, report any deterioration in skin integrity to charge nurse and physician."						
	priyololari.						
	Review of the	facility "pressure ulcer					
	report," from 10-23-12 thru 02-05-12						
	indicated the re	esident did not have					
	any "open areas."						
		02-14-13 indicated the					
		ad an area which					
		centimeters by 4.2					
	_	0.2 centimeters,					
	_	planchable, redness					
	with 3 open are	eas with slough."					
	The record lac	ked information the					
	plan of care wa						
		he resident's change in					
		area was not only red					
	with 3 open are	,					
	measurements	s as noted above.					
	Dhysisian and	ure dated 02 14 12					
		ers, dated 02-14-13 nursing staff to apply					
		t topically to buttocks,					
	,	ough after cleaning,					
	_	gaderm daily and prn					
	_	•					
	[as needed] dislodgement. Sodium chloride 0.9 % 250 c.c. [cubic						
		rigation, cleanse					
	_	uteal fold wound once a					
	1						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 47 of 84

	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155389	B. WIN			03/22/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
14/E0TD 4		OFNITED			TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	day and prn dis	slodgement.					
	During observations of the potential for to impaired modiabetes. Intercare included "needed such as a steep of the potential for to impaired modiabetes. Intercare included "needed such a steep of the potential for to impaired modiabetes and the potential for to impaired modiabetes. Intercare included "needed such a steep of the potential for to impaired modiabetes. Intercare included "needed such a steep of the potential for the potential f	ation on 03-22-13 at with the Director of idance, the wound on as measured. included 4.0 ath by 6.6 centimeters is 0.0 centimeters red around the wound. ow drainage with slight is blood noted during in. for Resident #49 was 0-13 at 9:00 a.m. uded, but were not lity, cerebral vascular retension, anemia, skin graft left arm, hemiplegia and 2nd These diagnoses ent at the time of the colan of care, dated ated the resident had it skin breakdown due bility, incontinence and ventions to this plan of positional devices as spillows, chair ourage repositioning in					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 48 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLI	ETED
		155389	B. WIN			03/22/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER			APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The resident so	cored 9/16 on the					
	Braden Risk as	ssessment scale which					
	indicated the re	esident was at a high					
	risk for develor	oing pressure ulcers.					
	During observa	ations on 03-19-13 at					
	_	ne assist dining room,					
		as seated in a reclining					
		ne nursing staff					
		reakfast meal to the					
	•	the resident remained					
		position. During					
		ervations on 03-19-13					
		10:52 a.m. and 1:05					
	· ·						
		ent remained seated in					
	_	heelchair without a					
	position chang	e.					
	During an obse	ervation on 03-20-13 at					
	8:09 a.m., the	resident was seated in					
	the wheelchair	in the assist dining					
		ident was in a reclined					
		sheet folded and					
	placed behind						
	'	8:52 a.m. the resident					
		the TV lounge and at					
		ed to the resident's					
	room. The res						
	-	the wheelchair during					
	these observat	tions.					
	During an obse	ervation on 03-20-12 at					
	_	equest was made to					
		dent for incontinence.					
		rdinator checked the					
	THE MIDS COOL	rumator checked the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 49 of 84

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155389	B. WING		03/22/2013
				ADDRESS, CITY, STATE, ZIP CODE	·
NAME OF F	PROVIDER OR SUPPLIER	₹		N TIBBS AVE	
	ARK HEALTHCARE	CENTER	INDIAI	NAPOLIS, IN 46222	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	,	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DETERENCT)	DATE
		dicated the resident			
	was incontiner	_			
	•	e Certified Nurse Aide			
		ne resident up when I			
	_	the morning around			
	7:00 a.m."				
	Observation or	n 03-21-13 at 8:14			
	a.m., the reside	ent was observed			
	seated in the v	vheelchair in the assist			
	dining room in	a reclined position.			
	_	on of breakfast the			
	resident was transported back to the				
		ained seated in the			
		t 10:24 a.m., the			
		ned in room, in same			
		2:40 p.m. the resident			
	l '	in assist dining room,			
		ne QMA (qualified			
		e) in a reclined			
		eet was observed rolled			
	1 ·				
		behind the resident's			
		idents right leg was			
		f the foot rest and			
	aangling to the	side of the wheelchair.			
	At 1:10 p.m. th	e resident remained in			
	wheelchair. Th	ne resident's right			
	arm/hand dang	gled to the right side of			
		. The resident's neck			
		nded and a sheet was			
	folded and place				
		d. At 1:30 p.m.,			
		es Aides # 18 and #20			
		insfer the resident from			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 50 of 84

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155389	B. WIN	IG		03/22/	2013
NAME OF I	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	NO VIDER OR SOLVER				TIBBS AVE		
WESTPA	ARK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		to bed. Upon removal					
		's incontinent brief the					
		al buttocks and rectal					
	_	ht red in color. During					
		n the Certified Nurse					
		it was the first time the					
		een laid down since					
	breakfast.						
	4. On 3/20/13 at 9:39 a.m., Resident						
	•	care was observed in					
		5 and unidentified CNA					
		esident's private area					
		incontinence brief					
		ng protective cream to					
	the resident's t	outtocks.					
	0.00040	0.05 D : 1 1					
		9:05 a.m., Resident					
		ved with his eyes					
		n his back in bed. Both					
		ated utilizing 2 pillows.					
		heels rested on the					
	,	ated) with the bottom of					
		eet touching the					
		e bed. The right heel					
		with the skin intact. At					
		, during an interview,					
		ed the resident was on					
	· ·	ssure reducing					
	mattress used	throughout the facility.					
	Dooldont #041-	record was reviewed					
		record was reviewed					
	on 3/20/13 at 8						
	_	noses included, but					
		d to, dysphagia,					
	malignant neo	plasm of prostate,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 51 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		155389	B. WING			03/22/	2013
NAME OF I	PROVIDER OR SUPPLIE	ER		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
=====					TIBBS AVE		
WESTPA	ARK HEALTHCAR	E CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	P	REFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		DR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		D (chronic kidney					
	1	CHF (congestive heart					
	,	quarterly Minimum Data					
		ent, dated 12/26/12,					
		resident required istance of 1 to 2					
		obility and activities of					
	l •	he BIMS (brief interview					
		tus) score was 14 with a					
		15 as interviewable.					
		13 as litterviewable.					
	The care plan	s indicated the					
	following:	is indicated the					
	l lollowing.						
	Care plan init	tially dated 9/21/12,					
	•	stage 2 Pressure Ulcer					
		n" was healed (with no					
		I). The interventions					
		were not limited to,					
		e device: Low air loss					
		ed; consult with MD as					
		erventions and					
		area; use positional					
		pillows) to keep boney					
		from direct contact with					
	one another."						
	Care plan, init	tially dated 10/1/12,					
	indicated "Pot	-					
	breakdown du	ue to impaired mobility					
	and incontine	nce." The goal was to					
		breakdown through the					
	duration of sta	ay/next 90 days. The					
		included, but were not					
		seline to buttocks and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 52 of 84

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155389	B. WIN	G		03/22/	2013
			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t .		1316 N	TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	scrotum every	shift and prn (as					
	needed);						
	bilat (bilateral) legs to be elevated on 2 pillows at all times when in bed."						
	2 pinews at an arrive when in sea.						
	Care plan, initially dated 12/7/12,						
	•	ge 4 (pressure ulcer)					
		el, which was indicated					
	as healed on 2						
		ncluded, but were not					
	limited to, "Elevate R (right) leg on 2						
	pillows at all times while in bed to						
	float heel".						
	A	- totticked an 4/40/40					
	•	s initiated on 1/16/13					
		ressure ulcer on R					
		which was indicated as					
	healed (with no	o date indicated).					
	A core plan wa	a initiated 2/7/12 for a					
	•	is initiated 3/7/13 for a					
		re ulcer on R inner					
	-	was indicated as					
	healed on 3/18	713.					
	Duning a see test see	niow on 2/22/42 -4					
	_	view on 3/22/13 at					
		N #19 (nurse who					
	•	d care) indicated					
		should have had a					
	_	ne indicated low air loss					
		re used when a					
	resident had a	pressure ulcer or was					
		pice services. She also					
	indicated Vaso	line was used as a skin					
	protectant to p	revent skin issues.					
	The LPN indica	ated Resident #21					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 53 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMP.			(X3) DATE S COMPL		
		155389	B. WIN			03/22/	2013
	PROVIDER OR SUPPLIER			1316 N	ADDRESS, CITY, STATE, ZIP CODE TIBBS AVE APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	a preventative	ad Vaseline applied as measure.					
	The "PRIMAR' FOR PRESSU DEVELOPMEN by the Director 3/22/13 at 10:1 policy indicated "PURPOSE: To assess, uporesident for princould contribut development a interventions a POLICY: The Norton Sc by a licensed is admitted to the done every weeks following quarterly there factors listed of preventative implemented a PROCEDURE:4. The Norton	Y RISK ASSESSMENT RE ULCER NT" policy was provided of Nursing (DON) on 0 a.m. This current d the following: on admission, each mary risk factors that e to pressure ulcer nd implement ccordingly. ale will be completed furse when a resident the facility. It will also week for four (4) g admission, and after. Based upon the in this assessment, easures shall be ccordingly.					
	admission, qua	arterly thereafter, nificant change in					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 54 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155389	B. WING		03/22/2013
NAME OF F	PROVIDER OR SUPPLIE	R	STREET .	ADDRESS, CITY, STATE, ZIP CODE	
				TIBBS AVE	
WESTPA	RK HEALTHCARE	CENTER	INDIAN	IAPOLIS, IN 46222	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	The "DECUBI"				
	-	SORES)" policy was			
	l :	e DON on 3/22/13 at			
		is current policy			
	indicated the following:				
	"DUDDOCE:				
	"PURPOSE:	residents having			
		s will receive necessary			
	•	romote healing, prevent			
	· ·	• .			
	new sores from developing, and prevent infection.				
	prevent intectiv	J11.			
	PROCEDUR	RES:			
		nurse will assess each			
		cubiti upon admission.			
		piti will be documented			
		riate facility form.			
		orders will be obtained.			
		reviewed periodically			
	for efficacy.				
	1	easurements shall be			
		designated, qualified			
	person.	J ., 41 - 11 - 11			
	'	to be made on the			
		lan relative to skin			
		s entry should include			
	location and st	•			
		ns to prevent further			
		r formation should be			
	instituted."				
	The "PREVEN	TION OF DECUBITUS			
	ULCERS (BED	OSORES)" policy was			
	,	e DON on 3/22/13 at			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 55 of 84

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155389	A. BUII B. WIN			03/22/	
NAME OF T	DOLUDED OF SUPPLY		D. WIN		DDRESS, CITY, STATE, ZIP CODE	L	
	ROVIDER OR SUPPLIER				TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
	10:10 a.m. Thi	is current policy					
	indicated the fo						
	"RECOGNIZ SIGNS/SYMPT PRESSURE So 1. Usually the forming on the *Heat; *Redder	ING THE TOMS OF A ORE: first signs of a bedsore resident's skin are: ned areas; A feeling of burning at					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 56 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155389		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING X3) DATE SURVI COMPLETED 03/22/2013			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N TIBBS AVE INDIANAPOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F000371 SS=E	483.35(i) FOOD PROCUR STORE/PREPAR The facility must (1) Procure food considered satisf local authorities; (2) Store, prepare under sanitary co Based on obse and interview, ensure a clean related to clean food preparatic kitchen observa Findings include During observa procedures on DA (Dietary Aid barbeque chick the machine us chicken would spinach was pretrieved a use counter and us amount of wate DA #18 witnes counter being of the containe #10, "you shou DA #10 pureed re-cleaning the	E, RE/SERVE - SANITARY - from sources approved or actory by Federal, State or and e, distribute and serve food onditions ervation, record review, the facility failed to and sanitary kitchen ning and handling of on equipment for 1 of 1 ed. de: ation of kitchen 3/20/13 at 10:50 a.m., de) #10 pureed ken. The DA indicated sed to puree the be washed before the ureed spinach. DA #10 ed towel from the sed it to wipe a small er out of the machine. sed the towel from the used to wipe the inside er and stated to DA aldn't have done that".	F000371	(1) A separate piece of equipment (bowl, lid, blade) wi used with the robot coupe for each individual food item/growhen pureeing. All equipment used will be washed and air dat the end of the process. This ensures there is no cross contamination between food items, and there is no wait tim while allowing the equipment air dry. This could have affect two residents receiving a pure diet. Our policy states that all utensils/equipment are to be a dried after use before being stored. Staff will be reminded in-serviced that no piece of equipment is to be towel dried. The RD and/or the DSM will monitor this daily for five days twice a week for the remainded the month, and then quarterly (2) Our policy is that all hand towels are to be in buckets whot in use. Our policy is that a cutting boards are cleaned an sanitized between each use. Could have affected on average 10% of residents who order grilled cheese sandwiches. We will institute a new procedure the handling/cutting of	ried s ne to ed eed eir and d. s, er of c. nen all ad This ge

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 57 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155389	B. WIN	IG		03/22/2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					TIBBS AVE	
WESTPA	ARK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
1110		3/20/13 at 11:10 a.m.,	+	0	sandwiches; all sandwiches wi	
	DA # 10 was observed to pick up two			be cut on the plate that it will be		
		spatula and another			served on. Staff will be in-serviced and reminded of	
		ensil from the counter		issues with cross contamination.	n.	
					The RD and/or the DSM will	
	in front of the warming area and set them on top of a cutting board. The				monitor this daily for five days, twice a week for the remainder	
	· ·	•			the month, and then quarterly.	-
	DA #10 did not clean the cutting board surface before placing three					
		. •				
	grilled cheese sandwiches on the					
	cutting board. The sandwiches were					
	·	idual bags for this				
	lunch service.					
	During an inter	view on 3/20/13 at				
	11:15 a.m., RD) #7 (registered				
	dietician) indica	ated dishes should be				
	air dried prior to	o use.				
	The "Storing U	tensils, Tableware, and				
	Equipment Pol	icy " was provided by				
	the RD #7 on 3	3/20/13 at 12:50 p.m.				
	This current po	licy indicated the				
	following:					
ı	" Procedure:					
	1. Make s	ure all utensils,				
	tablewa	are, equipment are air				
		efore removing from				
		rack and putting away.				
		use towels to dry				
		ent, etc.				
	1	ed and sanitized				
		and utensils should be				
l	Gydipinicht	and atonollo should be				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 58 of 84

i i			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	LDING	00	COMPL	
		155389	B. WIN	G		03/22/	2013
NAME OF P	ROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		a way that protects					
	them from	contamination.					
	Utensils sh	ould only be touched					
	by their har	ndles. Cups, glasses,					
	bowls, plate	es and similar items					
	should be h	nandled as as (sic) not					
		y surface that may					
		contact with food or a					
	resident's r						
		ing: Machine "policy					
		ne following:					
		elean, washed hands to					
	pull out clea	an racks, and allow to					
	air dry befo	re putting dishes away					
	for storage						
	During an inter	view with RD # 7 on					
	_	oximately 11:15 a.m.					
		lishes should be air					
	dried prior to us						
	-	JC.					
	3.1-21(i)(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 59 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155389	B. WING		03/22/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R			
I WESTEA		CENTED		TIBBS AVE	
WESTPA	RK HEALTHCARE	CENTER	INDIAN	IAPOLIS, IN 46222	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000431 SS=E	483.60(b), (d), (e) DRUG RECORD & BIOLOGICALS The facility must services of a lice establishes a sys and disposition of sufficient detail to reconciliation; and records are in ord all controlled drug periodically recond Drugs and biolog must be labeled accepted profess include the approceautionary instruct date when applied In accordance with the facility must is biologicals in lock proper temperate authorized person keys. The facility must permanently affix storage of control Schedule II of the Abuse Prevention and other drugs is when the facility drug distribution	e) PS, LABEL/STORE DRUGS Seemploy or obtain the ensed pharmacist who stem of records of receipt of all controlled drugs in the ensel of an accurate and determines that drug der and that an account of gs is maintained and enciled. Picals used in the facility in accordance with currently sional principles, and opriate accessory and ctions, and the expiration	IAU		DATE
	dose can be read Based on reco interview, the f the dispositon	dily detected.	F000431	(1) All nurses will be in-service on proper documentation regarding PRN medications. It our policy to document any P medication given and to also	is

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 60 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155389	B. WIN			03/22/	2013
			D. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹		1	TIBBS AVE		
WESTPA	ARK HEALTHCARE	CENTER			APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	as needed (prr	n), were dispensed in a			document its effectiveness.		
	manner to trac	k the administration			(2) The DON/ADON will review	V	
	and effectivene	ess of the medication			current resident's PRN medications to ensure correct		
	for 5 of 7 resid	ents randomly			documentation is being		
		e disposition of prn			done. (3) The Unit Manager, D	OON	
		ns (Resident #128,			and ADON will check the PRN		
	#51, #17, #56,	•			medication record for proper		
	, , , , , , , , , , , , , , , , ,	o. ,, , .			documentation for each reside		
	Findings include	de:			each shift for one week, one ti a day on random shifts for one		
					week, and monthly		
	1. Resident #	128's record was			thereafter.Nurses found to be		
	reviewed on 3/21/13 at 2:00 p.m. The				documenting incorrectly will be	9	
		noses included, but			counseled and in-serviced.		
	_	d to, right shoulder			(4)Facility management will discuss the results of the		
		vith arthroplasty,			discuss the results of the documentation checks at QA.		
					documentation checks at QA.		
		coronary artery					
	disease, and L	Diabetic Mellitus Type II.					
	The physician's	s order, dated 3/12/13,					
	was Oxycodon	e IR (immediate					
	release) (opoid	l analgesic for pain					
	-scheduled III	controlled substance)					
		(mg) by mouth (po)					
		urs (hrs) as need (prn)					
	for pain.	are (mo) do noca (pm)					
		o order detect 2/12/12					
		s order, dated 3/13/13,					
		e the Oxycodone IR to					
	5 mg po q 4 hr	s prn for pain.					
	The "Controlled	d Substances Record"					
		128's Oxycodone 5 mg					
		tablet (2.5 mg) orally q					
		` ', ', ', ', ', ', ', ', ', ', ', ', ',					
		ain. This record					
	indicated the fo	•					
	On 3/13/13 on	e 1/2 tablet was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 61 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155389	B. WING		03/22/2013
NAME OF F	PROVIDER OR SUPPLIE	R	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				TIBBS AVE	
WESTPA	ARK HEALTHCARE	ECENTER	INDIAN	IAPOLIS, IN 46222	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC!)	DATE
İ	dispensed at 8				
		o 1/2 tablets were			
	I = =	1:40 a.m. and at 10:40			
	p.m.;	o 1/2 tablets were			
	dispensed at 9				
	•	o 1/2 tablets were			
	dispensed at 4				
	aloporiscu at 4	u.m.			
	The Medication	n Administration			
		013 did not indicate			
	Oxycodone was administered to the				
	resident.				
	100.001.6.				
	The nurse's no	otes indicated the			
	following:				
	_	7:55 a.m. the resident			
	was resting qu				
		t 9:30 a.m. the resident			
		ed of increased pain to			
		der. At 11:30 a.m. the			
	_	omplianing of pain in			
		der with the prn pain			
	medication no	t effective, and the			
	physician was	notified.			
	On 3/16/13 an	d 3/17/13 no			
	information inc	licated the resident was			
	complaining of	f pain.			
		2:55 p.m., during an			
	interview the D	Director of Nursing			
	, ,	ed she was unaware if			
	the prn medica	ation, Hydrocodone,			
	_	n with no information			
	indicated in the	e resident's record.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 62 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETE	
		155389	B. WIN	G		03/22/201	13
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
====					TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CC	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	0= 2/22/42 =+ 4	1.40					
		1:43 p.m., during an lent #128 indicated he					
		ne had received a pain not. He indicated they					
		•					
		of his pills together in a					
	· ·	ould take them. He d not recall asking for					
		•					
	any pain medic	auon recenuy.					
	2. Resident #5	66's record was					
		21/13 at 3:00 p.m. The					
		noses included, but					
	_	d to, chronic pain and					
		ctive pulmonary					
	disease.	ouve paintenary					
	diccaco.						
	The physician's	s order, dated					
		Vicoden 5/325 mg					
	· ·	ablet every 6 hours as					
	needed for pair	•					
	The "Controlled	d Substances Record"					
	for Resident #5	56's					
	Hydrocodone-A	APAP (Vicodon) 5-325					
	1	1 tablet orally q 6 hrs					
		his record indicated the					
	following:						
	On 11/22/12 or	ne tablet was					
	dispensed at 5	a.m. and 9 p.m.;					
	On 11/23/12 or	ne tablet was					
	dispensed at 1	2 a.m., 6 a.m., and					
	5:15 p.m.;	·					
	On 11/24/12 or	ne tablet was					
	dispensed at 1	:50 a.m., 6 a.m., and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 63 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE S COMPL		
		155389	A. BUII B. WIN			03/22/	2013
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
WESTPA	RK HEALTHCARE	CENTER			TIBBS AVE APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	12 p.m.;	LSC IDENTIFYING INFORMATION)		TAG	DIA (CLACT)		DATE
	On 11/25/12 or	ne tahlet was					
	dispensed at 6						
	On 11/26/12 or	-					
	dispensed at 1						
	On 11/27/12 or	-					
		:30 a.m., 6 a.m., 12:30					
	•	indicated), and 7:30					
	p.m.;	•					
	On 11/28/12 or	ne tablet was					
	dispensed at 1	:30 a.m., 6:30 a.m.,					
	12:30 p.m., and	d 7:30 p.m.;					
	On 11/29/12 or	ne tablet was					
	dispensed at 7	:30 a.m., 2:15 p.m.,					
	and 9 p.m.;						
	On 11/30/12 or	ne tablet was					
	•	a.m. and 6:30 p.m.;					
		e tablet was dispensed					
		8 a.m., 12:30 p.m., and					
	6 p.m.;						
		e tablet was dispensed					
		.m., 12:15 p.m., 4:15					
	p.m. and 8:30						
		e tablet was dispensed					
		4:30 a.m., 12 p.m., and					
	6 p.m.;	a tablat was dispensed					
	at 3 a.m. and 5	e tablet was dispensed					
		e tablet was dispensed					
	at 2 a.m.;	ว เฉมเซเ พลง นเจคซเเงซน					
	·	e tablet was dispensed					
		:45 (a.m./p.m. not					
	•	40 p.m., and 8:45					
	p.m.;	i i piini, ana oliio					
		e tablet was dispensed					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 64 of 84

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155389		(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE S COMPL 03/22/	ETED	
	ROVIDER OR SUPPLIER		ST 13	316 N T	DDRESS, CITY, STATE, ZIP CODE FIBBS AVE APOLIS, IN 46222		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	at 2 a.m., 8:20 On 12/8/12 one at 4 a.m., 12 p. On 12/9/12 one at 3 a.m., 10 a. On 12/10/12 or dispensed at 10:45 p.m.; On 12/11/12 or dispensed at 9 On 12/12/12 or dispensed at 2 (a.m./p.m. not of the Medication Record for 11/2 not indicate Vioto the resident. The Nurse's not following: On 11/22/12 at pain medication with relief note on 11/23/12 at had complaine prn pain med with relief noted. On 12/9/12 at 3 medicated for promplained of a sesident #1	a.m., and 2:20 p.m.; e tablet was dispensed .m., and 9 p.m.; e tablet was dispensed .m., and 4 p.m.; ne tablet was 0 a.m., 4 p.m., and ne tablet was :30 a.m. and 8:35 p.m.; ne tablet was a.m. and 5:45 designated). n Administration 2012 and 12/2012 did codin was administered otes indicated the c 6:45 a.m. indicated n was given at 5 a.m. d. c 5 a.m. the resident d of pain one time and was given. No distress a.m. the resident was bain and had a headache.					
		noses included, but					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 65 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155389	B. WIN			03/22/2013	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			TIBBS AVE		
WESTPA	ARK HEALTHCARE	CENTER			APOLIS, IN 46222		
					711 OLIO, 114 40222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE		DATE
	were not limite						
	hypertension, depression, and						
	chronic kidney disease.						
	The physician	order, dated 1/18/13,					
	was Oxycodone 5/325 mg 1 po q 6 hr						
	prn pain.						
	The physician	order, dated 1/25/13,					
	was to change	Oxycodone 5/325 mg					
	_	s pren q 6 hr prn pain.					
		o prom q o m p m pomin					
	The "Controlled	d Substances Record"					
		17's Oxycodone 5/325					
		tabs orally q 6 hrs prn					
		• • •					
		record indicated the					
	following:						
		e tablet was dispensed					
		n., and 10:15 p.m.;					
		e tablet was dispensed					
	•	n., and (unclear) p.m.;					
	On 1/20/13 on	e tablet was dispensed					
	at 3:30 a.m., 3	p.m., and (unclear)					
	p.m.;						
	On 1/21/13 on	e tablet was dispensed					
	at 3 a.m. and 4	ł p.m.;					
		e tablet was dispensed					
	at 3 p.m.;	•					
	· '	e tablet was dispensed					
	at 9 a.m. and 2						
	On 1/25/13 two	•					
	dispensed at 9						
	On 1/26/13 two	! '					
	•	a.m., 3 p.m., and 9					
	p.m.;						
	On 1/27/13 two	o tablets were					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 66 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		155389	B. WIN			03/22/2	:013
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WESTDA	RK HEALTHCARE	CENTED			TIBBS AVE APOLIS, IN 46222		
				INDIAN	AFOLIS, IN 40222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		a.m., 9 a.m, and 3		IAG			DATE
	p.m.;	a.m., 9 a.m, and 5					
	On 1/28/13 two	tablets were					
		a.m., 2:50 (a.m./p.m.					
	not designated	, .					
	On 1/29/13 two						
		a.m. and 5 p.m.;					
	On 1/30/13 two	• •					
		a.m. and 4:30 p.m.;					
	On 1/31/13 two	•					
	dispensed at 6	a.m. and 5:30 p.m.;					
	On 2/1/13 two	tablets were dispensed					
	at 7 a.m.;						
	On 2/2/13 two	tablets were dispensed					
	at 9 a.m., 3 p.n	n., 11:30 p.m.;					
	On 2/3/13 two	tablets were dispensed					
	at 5 p.m. and 1	tablet was dispensed					
	at 9 p.m.;						
		tablets were dispensed					
	at 3 a.m.;						
		tablets were dispensed					
	at 7 a.m. and 5	•					
		tablets were dispensed					
	at 9 a.m.;	4abla4aa dia					
		tablet was dispensed					
	· ·	not designated);					
		tablets were dispensed					
	at 3 p.m. and 9 On 2/10/13 two	•					
		:30 a.m., 9 a.m., 3 p.m.					
	and 9 p.m.;	.ου α.iii., ε α.iii., ο μ.iii.					
	•	e tablet was dispensed					
		wo tablets were					
	dispensed at 3						
	On 2/12/13 two	•					
	511 27 127 10 two	, labioto word					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 67 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155389	A. BUI	LDING	00	COMPL 03/22/	
		133369	B. WIN		PRESIDENCE CONTROL CON	03/22/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER			APOLIS, IN 46222		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	dispensed at 9	•					
	On 2/13/13 two						
	dispensed at 1	•					
	On 2/14/13 two						
	dispensed at 3	•					
	On 2/15/13 two						
	•	:30 a.m. and 10:30 let dispensed at 10					
	(unclear);	ובו עוסףכווסכע מניוט					
	` ''	tablets were					
	On 2/16/13 two tablets were dispensed at 3:30 a.m., 9:30						
	(unclear), and 3 p.m.;						
	On 2/17/13 two	-					
		a.m. and 3 p.m. with 1					
	tablet dispense	-					
	-						
	The Medication	n Administration					
	Record for 1/20	013 and 2/2013 did not					
	1	done was administered					
	to the resident	related to the times					
	above.						
	The puree's se	tes indicated the					
	following:	tes indicated the					
		5 (unclear) the resident					
		pain medication one					
	time.						
		2:50 (unclear if a.m. or					
		an's order for a 1 time					
		ak through pain was					
	given.	U 1					
		2 p.m. resident was					
		increased pain. The					
	daughter was o	contacted to obtain the					
	resident's pain	medication dose at					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 68 of 84

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155389	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/22/2013
	PROVIDER OR SUPPLIER ARK HEALTHCARE CENTER	1316 N	ADDRESS, CITY, STATE, ZIP CODE TIBBS AVE APOLIS, IN 46222	•
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	home. On 1/25/13 at 7 a.m. the resident was complaining of knee pain and medication was given at 5 a.m. with relief. On 1/26/13 at 9:30 a.m. the resident was alert with no complaint of pain or discomfort at this time. On 1/28/13 at 11 a.m. the increase in the pain medication was indicated as adequately controlling the pain. On 2/10/13 at 4 a.m. resident was restless and give pain medication. She was indicated as resting quietly at 4:30 a.m. 4. Resident #51's record was reviewed on 3/21/13 at 3:20 p.m. The resident's diagnoses included, but were not limited to, spinal stenosis, hypertension, and diabetic mellitus. The physician's order, dated 2/16/13, was Norco 5/325 mg 1 to 2 tablets every 6 hours as needed for pain. The "Controlled Substances Record" for Resident #51's Norco (hydrocodone-APAP 5/325 mg) give 1 to 2 tabs per gastrostomy tube q 6 hrs prn for pain. This record indicated the following: On 2/16/13 two tablets were dispensed at 8 p.m.;			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 69 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		155389	B. WIN			03/22/	2013
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			TIBBS AVE		
WESTPA	ARK HEALTHCARE	CENTER			APOLIS, IN 46222		
				<u> </u>	711 32.13, 114 132.22		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	On 2/17/13 two	<u> </u>					
		a.m. and 7 a.m.;					
	On 2/18/13 two						
	dispensed at 9						
	•						
	On 2/23/13 two						
	•	p.m. and 9 p.m.;					
	On 2/24/13 two						
	<u> </u>	a.m., 4 p.m., and 10					
	p.m.;						
		tablets were dispensed					
	at 7 p.m.;						
		tablets were dispensed					
	at 2 different (ι	unclear) times.					
	The Medication	n Administration					
	Record for 2/20	013 did not indicate					
	Norco was adr	ninistered to the					
	resident related	d to the times above.					
	5. Resident #1	117's record was					
	reviewed on 3/	21/13 at 3:28 p.m. The					
		noses included, but					
	_	d to, bladder adeno					
		xiety, and chronic					
	kidney disease	J ,					
	l marie, diocase	July O.					
	The physician's	s order, dated 1/19/13,					
		one-APAP 5-325 mg					
		1 to 2 tablets orally					
		•					
	every 4 hours	as needed.					
	The "Control":	d Cubatanasa Dasardii					
		d Substances Record"					
	for Resident #						
	1	APAP 5/325 mg give 1					
	to 2 tabs per g	astrostomy tube q 6 hrs					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 70 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155389	B. WIN	G		03/22/	2013
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
====					TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
		his record indicated the					
	following:						
	On 1/19/13 two	tablata wara					
		a.m., 11:45 (a.m./p.m.					
	not designated	•					
	On 1/20/13 two	•					
		a.m. and 5 a.m.;					
	On 1/21/13 two						
		a.m., 9 a.m., and 9:30					
	p.m.;	a, a a, and also					
	On 1/22/13 two	tablets were					
		a.m. and 9:15 p.m.;					
	On 1/23/13 two	•					
	dispensed at 6	a.m. and 9 p.m.;					
	On 1/25/13 two	-					
	dispensed at 9	:45 p.m.;					
	On 1/26/13 two	tablets were					
	dispensed at 9	:30 p.m.;					
	On 1/27/13 two	tablets were					
	dispensed at 1	a.m., 5:10 a.m., and					
	9:40 p.m.;						
	On 1/28/13 two						
	dispensed at 1						
	On 1/29/13 two						
	dispensed at 9	•					
	On 1/30/13 two						
	•	a.m. and 10 p.m.;					
	On 1/31/13 two						
	dispensed at 9	-					
		tablet was dispensed					
	at 6 a.m.;	Andria August and Company					
		tablet was dispensed					
	at 5 a.m.;	tablata wana disessesses					
	On 2/3/13 two	tablets were dispensed					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 71 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155389	B. WING		03/22/2013
NAME OF F	PROVIDER OR SUPPLIEF	· · · · · · · · · · · · · · · · · · ·	STREET	ADDRESS, CITY, STATE, ZIP CODE	
				N TIBBS AVE	
WESTPA	ARK HEALTHCARE	CENTER	INDIA	NAPOLIS, IN 46222	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	at 12(unclear)				
	On 2/4/13 two tablets were dispensed				
	at 3:50 a.m.;				
		tablets were dispensed			
	at 5:45 a.m. ar	•			
		tablets were dispensed			
	at 5 a.m.;	tablata wara diananaad			
		tablets were dispensed			
	at 9:30 p.m.;	tablete were dispensed			
	On 2/8/13 two tablets were dispensed				
	at 5 a.m. and 8:30 p.m.; On 2/9/13 one tablet was dispensed				
	at 5 a.m.;	tablet was dispensed			
	· ·	e tablet was dispensed			
		tablets at 9:15 p.m.			
		was availabe from			
		8/13 with 2 tablets			
		2/23 at 10 p.m. and on			
		ets were dispensed at			
	2:30 a.m. and	-			
	The Medication	n Administration			
		013 and for 2/2013 did			
		orco was administered			
		related to the times			
	above.				
	On 3/22/13 at	10:10 a.m., the Director			
	of Nursing indi	cated she did not have			
	1	n related to the above			
	1	position on Resident			
	#128, #51, #17	7, #56, or #117.			
	3.1-25(b)(3)				
	I			I .	I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 72 of 84

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
		155389	B. WING		03/22/2013			
NAME OF P	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CODE				
WESTDA	RK HEALTHCARE	CENTED	1316 N TIBBS AVE INDIANAPOLIS, IN 46222					
				IAFULIO, IN 40222				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION			
TAG	•	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 73 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155389		(X2) MULTIPLE CO A. BUILDING	00	(X3) DATE SURVEY COMPLETED 03/22/2013	
		10000	B. WING		00/22/2010
NAME OF P	ROVIDER OR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP CODE	
WESTPA	RK HEALTHCARE	CENTER		TIBBS AVE IAPOLIS, IN 46222	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000441	483.65				
SS=F		ITROL, PREVENT			
	SPREAD, LINEN				
		establish and maintain an Program designed to			
		anitary and comfortable			
	-	to help prevent the			
		transmission of disease			
	and infection.				
		I.D.			
	(a) Infection Cont				
The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as					
	isolation, should l	pe applied to an individual			
	resident; and				
	` '	cord of incidents and			
	corrective actions	related to infections.			
	(b) Preventing Sp				
	` '	ction Control Program			
		resident needs isolation to			
	must isolate the r	d of infection, the facility			
		ust prohibit employees with			
	· · ·	disease or infected skin			
		ct contact with residents or			
	their food, if direc	t contact will transmit the			
	disease.				
		ust require staff to wash			
		each direct resident contact			
	accepted profess	ashing is indicated by			
	accepted profess	ισπαι μιασιισε.			
	(c) Linens				
		andle, store, process and			
	-	o as to prevent the spread			
	of infection.				
		rvation, interview, and	F000441	(1) All staff will be in-serviced	04/16/2013
	record reviews	, the facility failed to		regarding what isolation room	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 74 of 84

NAME OF PROVIDER OR SUPPLIER WESTPARK HEALTHCARE CENTER DEMONSTANCE AND CARRESTERM CONDECTION COMPLETION DATE DEMONSTANCE AND COMPLETION DATE PREFIX TAG PREF	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER WESTPARK HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL. TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL. TAG (COMPLETION DATE) ensure infection control practices were followed related to isolation set up for 2 of 2 isolation rooms observed. The facility failed to track symptoms of gastrointestinal distress during March 2013, which affected a total of 15 residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility infection control logs, dated from 9/2012 to 1/2013, indicated names of	AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A DUILDING 00		COMPLETED	
WESTPARK HEALTHCARE CENTER WESTPARK HEALTHCARE CENTER WESTPARK HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC DENTIFYING INFORMATION) REGULATORY OR LSC DENTIFY INFORMATION REGULATORY OR LOCAL TORS OF THE LSC TOWN INFORMATION REGULATORY OR LOCAL TORS OF THE LSC TOWN INFORMATION REGULATORY OR LSC DENTIFIC		155389			03/22/2013	
WESTPARK HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES ensure infection control practices were followed related to isolation set up for 2 of 2 isolation rooms observed. The facility failed to ensure infection surveillance for the month of February was completed. The facility failed to track symptoms of gastrointestinal distress during March 2013, which affected a total of 15 residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1316 N TIBBS AVE INDIANAPOLIS, IN 46222 ID PREFIX TAG SUMMARY STATEMENT OF CORRECTION (X5) COMPLETION DATE Supplies are to be available outside of the resident's room as well as where to get those supplies if they need to be replenished. The housekeeper in question will be in-serviced that if she is unsure of required PPE for an isolation room, she is to ask the charge nurse. CNA's will be in-serviced regarding proper handling of soiled linen. Monthly infection control logs will include the room number of the resident with the infection as well as the particular organism in order to more easily track any trends. If at any given time a particular infection is affecting 10% or more of the residents the infections will be mapped and color coded on a facility room floor plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room				ADDRESS CITY STATE ZIP CODE		
INDIANAPOLIS, IN 46222 INDIANAPOLIS, IN 46	NAME OF I	PROVIDER OR SUPPLIER				
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ensure infection control practices were followed related to isolation set up for 2 of 2 isolation rooms observed. The facility failed to ensure infection surveillance for the month of February was completed. The facility failed to track symptoms of gastrointestinal distress during March 2013, which affected a total of 15 residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control logs, dated from 9/2012 to 1/2013, indicated names of	WESTD	ADK HEALTHOADE CENTED				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ensure infection control practices were followed related to isolation set up for 2 of 2 isolation rooms observed. The facility failed to ensure infection surveillance for the month of February was completed. The facility failed to track symptoms of gastrointestinal distress during March 2013, which affected a total of 15 residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of	WESTER	ARK HEALTHCARE CENTER	INDIAN	NAPOLIS, IN 40222		
ensure infection control practices were followed related to isolation set up for 2 of 2 isolation rooms observed. The facility failed to ensure infection surveillance for the month of February was completed. The facility failed to track symptoms of gastrointestinal distress during March 2013, which affected a total of 15 residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of	1	SUMMARY STATEMENT OF DEFICIENCIES				
ensure infection control practices were followed related to isolation set up for 2 of 2 isolation rooms observed. The facility failed to ensure infection surveillance for the month of February was completed. The facility failed to track symptoms of gastrointestinal distress during March 2013, which affected a total of 15 residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of		· ·		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	
were followed related to isolation set up for 2 of 2 isolation rooms observed. The facility failed to ensure infection surveillance for the month of February was completed. The facility failed to track symptoms of gastrointestinal distress during March 2013, which affected a total of 15 residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of	TAG	, , , , , , , , , , , , , , , , , , ,	TAG		DATE	
well as where to get those supplies if they need to be replenished. The housekeeper in question will be in-serviced that if she is unsure of required PPE for an isolation room, she is to ask the charge nurse. CNA's will be in-serviced regarding proper an isolation room, she is to ask the charge nurse. CNA's will be in-serviced regarding proper handling of soiled linen. Monthly infection control logs will include the room number of the resident with the infection as well as the particular organism in order to more easily track any trends. If at any given time a particular infection is affecting 10% or more of the residents the infections will be mapped and color coded on a facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of		ensure infection control practices				
supplies if they need to be replenished. The housekeeper in question will be in-serviced that if she is unsure of required PPE for an isolation room, she is to ask the charge nurse. CNA's will be in-serviced regarding proper handling of soiled linen. Monthly infection control logs will include the room number of the residents with the infection as well as the particular organism in order to more easily track any trends. (2) The infection control log will be reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of		were followed related to isolation set			as	
observed. The facility failed to ensure infection surveillance for the month of February was completed. The facility failed to track symptoms of gastrointestinal distress during March 2013, which affected a total of 15 residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of replenished. The housekeeper in question will be in-serviced that if she is unsure of required PPE for an isolation room, she is to ask the charge nurse. CNA's will be in-serviced regarding proper handling of soiled linen. Monthly infection control logs will include the room number of the resident with the infection as well as the particular organism in order to more easily track any trends. If at any given time a particular infection is affecting 10% or more of the residents the infections will be mapped and color coded on a facility room floor plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room		up for 2 of 2 isolation rooms		_		
infection surveillance for the month of February was completed. The facility failed to track symptoms of gastrointestinal distress during March 2013, which affected a total of 15 residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of		observed. The facility failed to ensure			er in	
February was completed. The facility failed to track symptoms of gastrointestinal distress during March 2013, which affected a total of 15 residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of		· · · · · · · · · · · · · · · · · · ·		1 · · · · · · · · · · · · · · · · · · ·		
failed to track symptoms of gastrointestinal distress during March 2013, which affected a total of 15 residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of an isolation room, she is to ask the charge nurse. CNA's will be in-serviced regarding proper handling of soiled linen. Monthly infection control logs will include the room number of the resident with the infection as well as the particular organism in order to more easily track any trends. If at any given time a particular infection is affecting 10% or more of the residents the infections will be mapped and color coded on a facility room floor plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room				1 .		
gastrointestinal distress during March 2013, which affected a total of 15 residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of the charge nurse. CNA's will be in-serviced regarding proper handling of soiled linen. Monthly infection control logs will include the room number of the resident with the infection as well as the particular organism in order to more easily track any trends. If at any given time a particular infection is affecting 10% or more of the residents the infections will be mapped and color coded on a facility room floor plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room						
2013, which affected a total of 15 residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control logs, dated from 9/2012 to 1/2013, indicated names of		, ,				
residents (8 who remained in the facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of infection control logs will include the room number of the resident with the infection as well as the particular organism in order to more easily track any trends. If at any given time a particular infection is affecting 10% or more of the residents the infections will be mapped and color coded on a facility room floor plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room		1 9				
facility). This deficient practice had the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of the room number of the resident with the infection as well as the particular organism in order to more easily track any trends. If at any given time a particular infection is affecting 10% or more of the residents the infections will be mapped and color coded on a facility room floor plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room						
the potential to affect 47 of 47 residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of with the infection as well as the particular organism in order to more easily track any trends. If at any given time a particular infection is affecting 10% or more of the residents the infections will be mapped and color coded on a facility room floor plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room		· ·				
residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of particular organism in order to more easily track any trends. If at any given time a particular infection is affecting 10% or more of the residents the infections will be mapped and color coded on a facility room floor plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room		facility). This deficient practice had				
residents residing in the facility at this time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: I. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of Monthly infections facility at this any given time a particular infection is affecting 10% or more of the residents the infections will be mapped and color coded on a facility room floor plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room		the potential to affect 47 of 47				
time (Residents #14, #49, #96, #123, #125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of Image task any ticks any ticks any ticks any ticks any given time a particular infection is affecting 10% or more of the residents the infections will be mapped and color coded on a facility room floor plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room		residents residing in the facility at this				
#125, #126, #128, and #135). Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of infection is affecting 10% or more of the residents the infections will be mapped and color coded on a facility room floor plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room		· · · · · · · · · · · · · · · · · · ·			II at	
Findings included: 1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of of the residents the infections will be mapped and color coded on a facility room floor plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room		1			nore	
be mapped and color coded on a facility room floor plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room		1 120, 11 120, 11 120, and 11 100).		_		
1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of lacility foom loof plan to more easily track trends. (2) The infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room		Findings included:				
1. On 3/20/13 at 1:30 p.m., the facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of infection control log will be reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room		Findings included:		facility room floor plan to more	e	
facility's infection control program was reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of reviewed monthly for any trends throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room						
reviewed. Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of throughout the building. No other residents were affected by this isolated event. (3) The infection control log will include the room		•				
Monthly infection logs, dated from 9/2012 to 1/2013, indicated names of residents were affected by this isolated event. (3) The infection control log will include the room		facility's infection control program was				
9/2012 to 1/2013, indicated names of isolated event. (3) The infection control log will include the room		reviewed.				
9/2012 to 1/2013, indicated names of control log will include the room		Monthly infection logs, dated from				
contact log will include the recini		9/2012 to 1/2013, indicated names of		` '		
,				_		
lacked information regarding room present as well as the particular		·				
locations (room numbers) to track		1				
those infections. At the time of the		,				
10% of more of the residents the						
infection log review, the DON infections will be mapped and		, ·				
(Director of Nursing) indicated the color coded on a facility room		, · · · · · · · · · · · · · · · · · · ·				
location of the room numbers would floor plan to more easily track trends. Any time there are trends						
have to be known to track the observed, staff will be in-serviced		have to be known to track the		_		
identified infections. She indicated to ensure that everything possible		identified infections. She indicated				
the infection record for the month of is being done to prevent further		the infection record for the month of				
February 2013 had not been spread of infection. CNA's will be						
completed. in-serviced regarding proper		_				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155389	A. BUII B. WIN			03/22/2013	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	L			TIBBS AVE		
\\/ESTD\	RK HEALTHCARE	CENTER			APOLIS, IN 46222		
WESTER	ARK HEALTHCARE	CENTER		INDIAN	AFOLIS, IN 40222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					handling of soiled linen. Staff		
	On 3/21/2013	at 8:30 a.m.,			nurses will monitor q 2 hours	_	
	documentation indicated a wide spread outbreak of symptoms which included nausea, emesis (vomiting), and loose stools during March 2013. This outbreak affected all the areas of				during rounds to ensure prope handling of soiled linen. All sta		
					will be in-serviced regarding w		
					isolation room supplies are to		
					available outside of the reside		
					room as well as where to get		
		included Residents			those supplies if they need to	be	
	1	#123, #125, #126,			replenished. (4) The infection		
					control logs will be reviewed quarterly at the QA meeting.		
	#128, and #13	0.			quarterly at the QA meeting.		
	0 0 0/40/00	40 (44)					
		13 at 11 a.m., the					
		s were observed.					
	Supplies, locat	ed outside the isolation					
	rooms included	d gowns and masks,					
	but lacked glov	es.					
	3. During an o	bservation on 03-20-12					
		esident #49 was					
	transferred						
	to a clean bed	via a hover lift					
		rovided by Certified					
		CNA) #18 and #20.					
		ns were removed from					
		sident after the					
		een turned from side to					
	side, and CNA	#20 placed the urine					
	saturated linen	s at the end of the					
	clean bed. The	e CNA cleaned the					
	resident and pi	ovided pericare, then					
		soiled linens and then					
	1 '	n the other side of the					
	resident in the						
		olean bea.					
	On 03 20 12 a	t 11:15 a.m. during an					
		t 11:15 a.m., during an					
	interview an ur	naentitiea	1				I

i '			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED				
		155389	B. WIN	G		03/22/	2013
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	ROVIDER OR SOLI EIER				TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER		INDIAN.	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	•	ndicated she was					
		y a resident was in					
	isolation and what precautions were needed. The Housekeeper stated, "I don't know what's going on with the						
		room, all I know is I					
		on when I go in there to					
	clean the room	."					
	_	solation Precautions"					
		rided by the DON on					
		p.m. This current					
	policy indicated	the following:					
		n an adequate array of					
		es (i.e., gloves, gowns,					
		needed) near the					
		so that appropriate					
	•	ing can be easily put					
	on before enter	ring the isolation room;					
	"						
		contact isolation -					
		itionAll disease or					
		ded in this category are					
		y by close or direct					
	contact"						
	0.4.40/1.1/41/41						
	3.1-18(b)(1)(A)						
	3.1-19(f)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 77 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
OF CORRECTION	IDENTIFICATION NUMBER:	A DI III	DING	00	COMPLETED	
	155389				03/22/2013	
		B. WIN		ADDRESS CITY STATE ZID CODE		
ROVIDER OR SUPPLIER						
	CENTED					
RN HEALTHCARE	CENTER		INDIAN	APOLIS, IN 46222		
SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	re I	COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
483.70(h) SAFE/FUNCTION TABLE ENVIRON The facility must personal states and commendate and interview, the ensure a clean environment refor 1 of 1 aviary the potential to residents in the Findings includ On 3/20/13 at 3 was observed. Fecal-like mater the glass windown perches, and on back of the aviary area Friday. She incomplete a sit was only clean it today a it was only clean on 3/21/12 at 4 interview, the All the aviary area week by house	NAL/SANITARY/COMFOR a provide a safe, functional, infortable environment for ad the public. Invation, record review, the facility failed to and sanitary lated to the aviary area of observed. This had impact 47 of 47 a facility. The facility failed to and sanitary lated to the aviary area of observed areas of facility. The facility failed to and sanitary lated to the aviary solided areas of facility and the aviary wall in the facy contained area. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility. The facility failed to and sanitary area of facility facility. The facility failed to and sanitary area of facility facility facility facility. The facility failed to and sanitary area of facility facility. The facility fac	F00		(1) We have experienced difficulty finding a consistent outside contractor to maintain aviary in a satisfactory manner. The cabinets and glas are discolored and in poor condition. This issue was brou to our resident council preside on 4/8/13 to discuss these issuit was decided that the birds with the birds with the satisfactory manner. The cabinets and glass are discolored and in poor condition. This issue was brout to sure resident council preside on 4/8/13 to discuss these issuit was decided that the birds with the birds with the satisfactory of the condition	the s ght nt ues.	DATE 04/16/2013
P .	ROVIDER OR SUPPLIER RK HEALTHCARE SUMMARY ST (EACH DEFICIENT REGULATORY OR 483.70(h) SAFE/FUNCTION TABLE ENVIRON The facility must psanitary, and comresidents, staff and Based on obset and interview, the ensure a clean environment refor 1 of 1 aviary the potential to residents in the Findings includ On 3/20/13 at 3 was observed. Findings includ On 3/20/13 at 3 was observed. Findings includ On 3/21/13 at 3 interview, House the glass windown perches, and or back of the aviary area Friday. She included the aviary area week by house indicated the P	IDENTIFICATION NUMBER: 155389 ROVIDER OR SUPPLIER RK HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ROVIDER OR SUPPLIER RK HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure a clean and sanitary environment related to the aviary area for 1 of 1 aviary observed. This had the potential to impact 47 of 47 residents in the facility. Findings include: On 3/20/13 at 3:00 p.m., the aviary was observed. Soiled areas of fecal-like material was observed on the glass windows, the bird's wooden perches, and on the aviary wall in the back of the aviary contained area. On 3/21/13 at 10:10 a.m., during an interview, Housekeeper #26 indicated the aviary area was cleaned every Friday. She indicated she had helped clean it today although she indicated it was only cleaned once a week. On 3/21/12 at 4:30 p.m., during an interview, the Administrator indicated the aviary area was cleaned 3 times a week by housekeeping. He also indicated the Plexiglas area was	ROVIDER OR SUPPLIER RK HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure a clean and sanitary environment related to the aviary area for 1 of 1 aviary observed. This had the potential to impact 47 of 47 residents in the facility. Findings include: On 3/20/13 at 3:00 p.m., the aviary was observed. Soiled areas of fecal-like material was observed on the glass windows, the bird's wooden perches, and on the aviary wall in the back of the aviary contained area. On 3/21/13 at 10:10 a.m., during an interview, Housekeeper #26 indicated the aviary area was cleaned every Friday. She indicated she had helped clean it today although she indicated it was only cleaned once a week. On 3/21/12 at 4:30 p.m., during an interview, the Administrator indicated the aviary area was cleaned 3 times a week by housekeeping. He also indicated the Plexiglas area was	ROVIDER OR SUPPLIER RK HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility. Findings include: On 3/20/13 at 3:00 p.m., the aviary was observed. Soiled areas of fecal-like material was observed on the glass windows, the bird's wooden perches, and on the aviary wall in the back of the aviary area was cleaned every Friday. She indicated the aviary area was cleaned every Friday. She indicated she had helped clean it today although she indicated it was only cleaned once a week. On 3/21/12 at 4:30 p.m., during an interview, the Administrator indicated the aviary area was cleaned 3 times a week by housekeeping. He also indicated the Plexiglas area was	IDENTIFICATION NUMBER: 150389 A BUILDING BUILDI

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 78 of 84

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2013 FORM APPROVED OMB NO. 0938-0391

-	OF CORRECTION	IDENTIFICATION NUMBER: 155389	A. BUII B. WIN	LDING	00	COMPL 03/22/	ETED
NAME OF PROVIDER OR SUPPLIER WESTPARK HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N TIBBS AVE INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
	provided by the 3/21/13 at 8:15 policy indicated. "It is the policy Healthcare that cleaned 3 times housekeeping of Monday, Wedne this time the bir water and seed cleaned inside the bottom of the changed quarte the cage will be a safe and san	of Westpark It the aviary will be Is weekly by the Idepartment on It the session of the session					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 79 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		155389	B. WING		03/22/2013
NAME OF P	ROVIDER OR SUPPLIEF	}	STREET	ADDRESS, CITY, STATE, ZIP CODE	•
				TIBBS AVE	
WESTPA	RK HEALTHCARE	CENTER	INDIAN	IAPOLIS, IN 46222	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		C LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCI)	DATE
F000516 SS=C	483.75(I)(3), 483	NFO, SAFEGUARD			
33-0	CLINICAL RECC				
	A facility may not release information that is resident-identifiable to the public.				
	The feetlife many				
	The facility may release information that is resident-identifiable to an agent only in				
		a contract under which the			
		to use or disclose the			
	·	pt to the extent the facility			
	itself is permitted	to do so.			
	The facility must	safeguard clinical record			
	The facility must safeguard clinical record information against loss, destruction, or				
	unauthorized use				
	Based on obse	ervation and interview,	F000516	(1) All discharged resident	04/16/2013
	the facility faile	ed to ensure resident's		records and currentresident's	.
	medical record	Is were stored securely		records that have been thinned will be stored in a file cabinet	
	and in a manne	er to prevent possible		amedical records room that w	
	damage to the	medical records for 1		remain locked at all times. (2)	
	of 1 observation	on of the medical		other residents were affected	
	storage room.	This had the potential		the deficient practice (3) A loc	
	to impact 47 of	f 47 residents residing		has been installed on the med records door that remains loc	
	in the facility a	nd 51 of 51 residents		by default. No medical record	
	discharged from	m 1/20/13 through		will be stored in boxes. They	
	3/21/13.			all be stored in metal filing	
				cabinets. (4) The corrective	_
	Findings include	de:		action will be monitored by the DON and Administrator. The	e
				DON or Administrator will che	ck
		3:00 p.m. with the		the medical records room wee	ekly.
	Director of Nur	rsing (DON) and the			
	Assistant Direc	ctor of Nursing (ADON),			
	the medical red	cord storage room was			
	observed unloa	cked with a ceiling			
	sprinkler syste	m in place and with 17			
	cardboard box	es full of files on top of			
	the file cabinet	s. During an interview			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 80 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155389		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/22/2013		
	PROVIDER OR SUPPLIER		B. WIN	1316 N	ADDRESS, CITY, STATE, ZIP CODE TIBBS AVE APOLIS, IN 46222	<u>I</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSG INFORMATIONS		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	at this same tir the medical sto have been lock indicated the 1 contained resid and should have secure location potential environmental enviro	ne, the DON indicated brage room should sed. The DON also 7 cardboard boxes dents' medical records we been stored in a nand protected from bonnental damage. 3:35 am during an DON indicated the less contained idents' records from 1:40 p.m., the list of idents from 1/20/12 was provided by the licated 51 residents had led during this period.		TAG			DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 81 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155389	A. BUILDI B. WING	DVII		03/22/2013	
				CTDEET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
WESTDA		CENTED			TIBBS AVE		
WESTPA	RK HEALTHCARE	CENTER		INDIAINA	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES]	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Т	ΓAG	DEFICIENCY)		DATE
F000520	483.75(o)(1)						
SS=B		E-MEMBERS/MEET					
	QUARTERLY/PL	ANS					
	A facility must ma	· · · · · · · · · · · · · · · · · · ·					
		assurance committee					
		director of nursing services;					
		nated by the facility; and at					
	least 3 other men	nbers of the facility's staff.					
	The quality asses	sment and assurance					
		at least quarterly to					
		th respect to which quality					
		assurance activities are					
	necessary; and d	evelops and implements					
	•	of action to correct					
	identified quality	deficiencies.					
		ecretary may not require					
		records of such committee					
		such disclosure is related					
	•	e of such committee with					
	the requirements	of this section.					
	Cood faith -#-	ata bu tha committee to					
		ots by the committee to					
		ct quality deficiencies will basis for sanctions.					
	Based on reco		F0005	₅₂₀	(1) Chapitia arganisms related	to	04/16/2013
			1.0003)20	(1) Specific organisms related infections will be added to the	ıU	07/10/2013
		acility failed to ensure			infections will be added to the		
		ality Assessment and			where in the building the infect	ion	
	Assurance prog	gram for			was located. All resident skin		
	tracking/prever	nting the spread of			sheets and treatments will be		
	infections. The	e facility failed to			reviewed to ensure that all		
	ensure an effec				residents have appropriate		
		nd Assurance program			pressure ulcer prevention		
		. •			methods in place. (2) The		
	· ·	evention interventions			DON/ADON will monitor that		
		nsure a system for			narcotics signed out are		
		f narcotic sign out			documented as given on the M		
	sheets with the	Medication			to identify other residents with	the	
					potential to be affected. Skin		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet Page 82 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDDIC	00	COMPLETED	
		155389		LDING		03/22/2013	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
14/E0TD 4		OFNITED			TIBBS AVE		
WESTPARK HEALTHCARE CENTER			INDIAN	APOLIS, IN 46222			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	1
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	Administration	Record.			sheets and		
					treatment/preventative method	s	
	Findings include:				will be reviewed to identify oth	er	
					residents with the potential to		
					affected. (3) Licensed nurses	l l	
	•	view on 03-22-13 at			be in-serviced regarding prope		
	10:00 a.m., the	e Quality Assessment			documentation of medications	. in	
	and Assurance	e nurse indicated the			regards to infection, specific		
	team members	met in February 2013.			organisms and location will be discussed during the quarterly	ο Δ	
		•			meeting.During the quarterly (
	When question	ned about Infection			meeting, management will	· .	
	control, the Quality Assessment and				discuss any discrepancies in		
	· ·	•			regards to narcotics signed ou	t l	
		rse indicated the			and what is documented as		
		ses tracked the			administered. Also during the	QA AÇ	
	infections and	listed the infections by			meeting, while discussing		
	the facility halls	s. The nurse further			infections, particular organism	3	
	indicated she v	vas unsure if specific			will be discussed, along with		
	organisms wer	e tracked. and			where in the building the		
		s not discussed in the			infections were located and		
		sment and Assurance			whether any patterns were identified.During QA		
	meetings.	ment and Assurance			management will continue to		
	i meetings.				discuss pressure ulcers and o	her	
					skin conditions.		
	The Quality As						
	Assurance (QA	AA) nurse indicated					
	nursing staff w	ere responsible for					
	ensuring comp	liance with resident					
		d pressure reducing					
	l ·	The nurse indicated					
		last quarter 2012 the					
	_						
	1	light increase in					
	pressure ulcers	S.					
	The QAA nurse	e indicated gradual					
	dose reduction	s and quantities of					
		n (as needed) narcotic					
		ns were discussed in					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2013 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155389	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPL 03/22	ETED
	PROVIDER OR SUPPLIER ARK HEALTHCARE CENTER	STREET A 1316 N	ADDRESS, CITY, STATE, ZIP CODE TIBBS AVE IAPOLIS, IN 46222		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	meetings. The QAA nurse indicated there had not been discussion in regard to ensuring narcotics signed out were documented as given on the resident's Medication Administration Record (ensuring the quantity of narcotic medication signed out matched the quantity of medication indicated as given on the MAR). 3.1-52(b)(2)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TM6211

Facility ID: 000473

If continuation sheet

Page 84 of 84